S. HRG. 106–491, PT. 2

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

S. 2526

TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND SUCH ACT

MAY 10, 2000
WASHINGTON, DC

PART 2

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APPENDIX

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, MAY 10, 2000

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to other business, at 10:02 a.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senator Campbell.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. We will now move to the reauthorization of the Indian Health Care Improvement Act, S. 2526, which I introduced yesterday and was joined by the Vice Chairman and Senator McCain.

The current Indian health policy was presented in the 1970 Nixon Message to Congress on Indian Affairs, continued through the Indian Self-Determination and Self-Governance Act and is reaffirmed with the introduction of this legislation.

The legislation reaffirms the core principles that were part of the original act: that Federal health services are consistent with the unique Federal tribal relationship; that a goal of the United States is to provide the quantity and quality of services to raise the health status of Indian people; and that tribal participation in the planning and management of health services should be maximized.

Today we will discuss the first three titles of the bill. We will hear from panel 1, dealing with health service. Then we will continue with panel 2, which will focus on facilities construction.

[Text of S. 2526 follows:]

II

106TH CONGRESS
2D SESSION

S. 2526

To amend the Indian Health Care Improvement Act to revise and extend such Act.

IN THE SENATE OF THE UNITED STATES

MAY 9, 2000

Mr. CAMPBELL (for himself and for Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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A BILL

To amend the Indian Health Care Improvement Act to revise and extend such Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Indian Health Care Improvement Act Reauthorization of 2000".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—REAUTHORIZATION AND REVISIONS OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

SEC. 101. AMENDMENT TO THE INDIAN HEALTH CARE IMPROVEMENT ACT.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

"(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

"(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

"SEC. 2. FINDINGS.

"Congress makes the following findings:

"(1) Federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the Constitution, treaties, Federal laws, and the course

of dealings of the United States with Indian Tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

"(2) From the time of European occupation and colonization through the 20th century, the policies and practices of the United States caused or contributed to the severe health conditions of Indians.

"(3) Indian Tribes have, through the cession of over 400,000,000 acres of land to the United States in exchange for promises, often reflected in treaties, of health care secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States.

"(4) The population growth of the Indian people that began in the later part of the 20th century increases the need for Federal health care services.

"(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than that of the general population, and to provide for the

maximum participation of Indian Tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

"(6) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of illnesses among, and unnecessary and premature deaths of, Indians.

"(7) Despite such services, the unmet health needs of the American Indian people remain alarmingly severe, and even continue to increase, and the health status of the Indians is far below the health status of the general population of the United States.

"(8) The disparity in health status that is to be addresses is formidable. In death rates for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher than the death rate for all races in the United States, a pneumonia and influenza death rate that is 71 percent higher, a tuberculosis death rate that is 533 percent higher, and a death rate from alcoholism that is 627 percent higher.

"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people—

"(1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;

"(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto;

"(3) in order to raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto, to permit Indian Tribes and tribal organizations to set their own health care priorities and establish goals that reflect their unmet needs;

"(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each geographic service area is raised to at least the level of that of the general population;

"(5) to require meaningful, active consultation with Indian Tribes, Indian organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

"(6) that funds for health care programs and facilities operated by Tribes and tribal organizations be provided in amounts that are not less than the funds that are provided to programs and facilities operated directly by the Service.

"SEC. 4. DEFINITIONS.

"In this Act:

"(1) ACCREDITED AND ACCESSIBLE.—The term 'accredited and accessible', with respect to an entity, means a community college or other appropriate entity that is on or near a reservation and accredited by a national or regional organization with accrediting authority.

"(2) AREA OFFICE.—The term 'area office' mean an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary of the Indian Health as established under section 601.

"(4) CONTRACT HEALTH SERVICE.—The term 'contract health service' means a health service that is provided at the expense of the Service, Indian Tribe, or tribal organization by a public or private medical provider or hospital, other than a service funded under the Indian Self-Determination and Education Assistance Act or under this Act.

"(5) DEPARTMENT.—The term 'Department', unless specifically provided otherwise, means the Department of Health and Human Services.

"(6) FUND.—The terms 'fund' or 'funding' mean the transfer of monies from the Department to any eligible entity or individual under this Act by any legal means, including funding agreements, contracts, memoranda of understanding, Buy Indian Act contracts, or otherwise.

"(7) FUNDING AGREEMENT.—The term 'funding agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, functions, services and activities to Tribes and tribal organizations from the Secretary under the authority of the Indian Self-Determination and Education Assistance Act.

"(8) HEALTH PROFESSION.—The term 'health profession' means allopathic medicine, family medi-

cine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, and allied health professions, or any other health profession.

"(9) HEALTH PROMOTION; DISEASE PREVENTION.—The terms 'health promotion' and 'disease prevention' shall have the meanings given such terms in paragraphs (1) and (2) of section 203(c).

"(10) INDIAN.—The term 'Indian' and 'Indians' shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.

"(11) INDIAN HEALTH PROGRAM.—The term 'Indian health program' shall have the meaning given such term in section 110(a)(2)(A).

"(12) INDIAN TRIBE.—The term 'Indian tribe' shall have the meaning given such term in section 4(e) of the Indian Self Determination and Education Assistance Act.

"(13) RESERVATION.—The term 'reservation' means any Federally recognized Indian tribe's res-

ervation, Pueblo or colony, including former reservations in Oklahoma, Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act, and Indian allotments.

"(14) SECRETARY.—The term 'Secretary', unless specifically provided otherwise, means the Secretary of Health and Human Services.

"(15) SERVICE.—The term 'Service' means the Indian Health Service.

"(16) SERVICE AREA.—The term 'service area' means the geographical area served by each area office.

"(17) SERVICE UNIT.—The term 'service unit' means—

"(A) an administrative entity within the Indian Health Service; or

"(B) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

"(18) TRADITIONAL HEALTH CARE PRACTICES.—The term 'traditional health care practices'

means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to western healing sciences) which embodies the influences or forces of innate tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which calls upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation and maintenance of health, well-being, and life's harmony.

"(19) TRIBAL ORGANIZATION.—The term 'tribal organization' shall have the meaning given such term in section 4(l) of the Indian Self Determination and Education Assistance Act.

"(20) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' shall have the meaning given such term in section 126 (g)(2).

"(21) URBAN CENTER.—The term 'urban center' means any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

"(22) URBAN INDIAN.—The term 'urban Indian' means any individual who resides in an urban center and who—

"(A) regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940;

"(B) is an Eskimo or Aleut or other Alaskan Native;

"(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

"(D) is determined to be an Indian under regulations promulgated by the Secretary.

"(23) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the participation of all interested Indian groups and individuals, and which is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"SEC. 101. PURPOSE.

"The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health services to Indian people.

"SEC. 102. GENERAL REQUIREMENTS.

"(a) SERVICE AREA PRIORITIES.—Unless specifically provided otherwise, amounts appropriated for each fiscal year to carry out each program authorized under this title shall be allocated by the Secretary to the area office of each service area using a formula—

"(1) to be developed in consultation with Indian Tribes, tribal organizations and urban Indian organizations; and

"(2) that takes into account the human resource and development needs in each such service area.

"(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously con-

sult with representatives of Indian tribes, tribal organizations, and urban Indian organizations to prioritize the utilization of funds provided under this title within the service area.

"(c) REALLOCATION.—Unless specifically prohibited, an area office may reallocate funds provided to the office under this title among the programs authorized by this title, except that scholarship and loan repayment funds shall not be used for administrative functions or expenses.

"(d) LIMITATION.—This section shall not apply with respect to individual recipients of scholarships, loans or other funds provided under this title (as this title existed 1 day prior to the date of enactment of this Act) until such time as the individual completes the course of study that is supported through the use of such funds.

"SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall make funds available through the area office to public or nonprofit private health entities, or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

"(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

"(A) to enroll in courses of study in such health professions; or

"(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

"(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

"(3) establishing other programs which the area office determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

"(b) ADMINISTRATIVE PROVISIONS.—

"(1) APPLICATION.—To be eligible to receive funds under this section an entity described in subsection (a) shall submit to the Secretary, through the appropriate area office, and have approved, an application in such form, submitted in such manner, and containing such information as the Secretary shall by regulation prescribe.

"(2) PREFERENCE.—In awarding funds under this section, the area office shall give a preference to applications submitted by Indian tribes, tribal organizations, or urban Indian organizations.

"(3) AMOUNT.—The amount of funds to be provided to an eligible entity under this section shall be determined by the area office. Payments under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations promulgated pursuant to this Act.

"(4) TERMS.—A funding commitment under this section shall, to the extent not otherwise prohibited by law, be for a term of 3 years, as provided for in regulations promulgated pursuant to this Act.

"(c) DEFINITION.—For purposes of this section and sections 104 and 105, the terms 'Indian' and 'Indians' shall, in addition to the definition provided for in section 4, mean any individual who—

"(1) irrespective of whether such individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940;

"(2) is an Eskimo or Aleut or other Alaska Native;

"(3) is considered by the Secretary of the Interior to be an Indian for any purpose; or

"(4) is determined to be an Indian under regulations promulgated by the Secretary.

"SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide scholarships through the area offices to Indians who—

"(1) have successfully completed their high school education or high school equivalency; and

"(2) have demonstrated the capability to successfully complete courses of study in the health professions.

"(b) PURPOSE.—Scholarships provided under this section shall be for the following purposes:

"(1) Compensatory preprofessional education of any recipient. Such scholarship shall not exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act).

"(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved

course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act) except that an extension of up to 2 years may be approved by the Secretary.

"(c) USE OF SCHOLARSHIP.—Scholarships made under this section may be used to cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school.

"(d) LIMITATIONS.—Scholarship assistance to an eligible applicant under this section shall not be denied solely on the basis of—

"(1) the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; or

"(2) the applicant's eligibility for assistance or benefits under any other Federal program.

"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

"(a) SCHOLARSHIPS.—

"(1) IN GENERAL.—In order to meet the needs of Indians, Indian tribes, tribal organizations, and urban Indian organizations for health professionals, the Secretary, acting through the Service and in ac-

cordance with this section, shall provide scholarships through the area offices to Indians who are enrolled full or part time in accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall, except as provided in subsection (b), be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l).

"(2) NO DELEGATION.—The Director of the Service shall administer this section and shall not delegate any administrative functions under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act.

"(b) ELIGIBILITY.—

"(1) ENROLLMENT.—An Indian shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full or part time in a course of study referred to in subsection (a)(1).

"(2) SERVICE OBLIGATION.—

"(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under

that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year for year obligation, by service—

"(i) in the Indian Health Service;

"(ii) in a program conducted under a funding agreement entered into under the Indian Self-Determination and Education Assistance Act;

"(iii) in a program assisted under title V; or

"(iv) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(B) DEFERRING ACTIVE SERVICE.—At the request of any Indian who has entered into a contract referred to in subparagraph (A) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary

shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

"(i) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service that is required under this section.

"(ii) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

"(iii) The active duty service obligation will be served in the health profession of that individual, in a manner consistent with clauses (i) through (iv) of subparagraph (A).

"(C) NEW SCHOLARSHIP RECIPIENTS.—A recipient of an Indian Health Scholarship that

is awarded after December 31, 2001, shall meet the active duty service obligation under such scholarship by providing service within the service area from which the scholarship was awarded. In placing the recipient for active duty the area office shall give priority to the program that funded the recipient, except that in cases of special circumstances, a recipient may be placed in a different service area pursuant to an agreement between the areas or programs involved.

"(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

"(3) PART-TIME ENROLLMENT.—In the case of an Indian receiving a scholarship under this section

who is enrolled part time in an approved course of study—

"(A) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the appropriate area office;

"(B) the period of obligated service described in paragraph (2)(A) shall be equal to the greater of—

"(i) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the area office); or

"(ii) two years; and

"(C) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254l(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

"(4) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with

the area office pursuant to a scholarship under this section and who—

"(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) is dismissed from such educational institution for disciplinary reasons;

"(iii) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

"(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract;

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A) an individual breaches his or her written contract by failing either to begin such individual's service obligation under this section or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(C) DEATH.—Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

"(D) WAIVER.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the appropriate area office, Indian tribe, tribal organization, and urban Indian organization, determines that—

"(i) it is not possible for the recipient to meet that obligation or make that payment;

"(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

"(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

"(E) HARDSHIP OR GOOD CAUSE.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

"(F) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds

that the nondischarge of the obligation would be unconscionable.

"(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.—

"(1) PROVISION OF FUNDS.—

"(A) IN GENERAL.—The Secretary shall make funds available, through area offices, to Indian Tribes and tribal organizations for the purpose of assisting such Tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

"(B) LIMITATION.—The Secretary shall ensure that amounts available for grants under subparagraph (A) for any fiscal year shall not exceed an amount equal to 5 percent of the amount available for each fiscal year for Indian Health Scholarships under this section.

"(C) APPLICATION.—An application for funds under subparagraph (A) shall be in such form and contain such agreements, assurances and information as consistent with this section.

"(2) REQUIREMENTS.—

"(A) IN GENERAL.—An Indian Tribe or tribal organization receiving funds under paragraph (1) shall agree to provide scholarships to

Indians in accordance with the requirements of this subsection.

"(B) MATCHING REQUIREMENT.—With respect to the costs of providing any scholarship pursuant to subparagraph (A)—

"(i) 80 percent of the costs of the scholarship shall be paid from the funds provided under paragraph (1) to the Indian Tribe or tribal organization; and

"(ii) 20 percent of such costs shall be paid from any other source of funds.

"(3) ELIGIBILITY.—An Indian Tribe or tribal organization shall provide scholarships under this subsection only to Indians who are enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in this Act.

"(4) CONTRACTS.—In providing scholarships under paragraph (1), the Secretary and the Indian Tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

"(A) obligate such recipient to provide service in an Indian health program (as defined in section 110(a)(2)(A)) in the same service

area where the Indian Tribe or tribal organization providing the scholarship is located, for—

"(i) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

"(ii) such greater period of time as the recipient and the Indian Tribe or tribal organization may agree;

"(B) provide that the scholarship—

"(i) may only be expended for—

"(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

"(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B), such amount to be reduced pro rata (as determined by the

Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

"(ii) may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i);

"(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

"(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to the health profession involved.

"(5) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An individual who has entered into a written contract with the Sec-

retary and an Indian Tribe or tribal organization under this subsection and who—

"(i) fails to maintain an acceptable level of academic standing in the education institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) is dismissed from such education for disciplinary reasons;

"(iii) voluntarily terminates the training in such an educational institution for which he or she has been provided a scholarship under such contract before the completion of such training; or

"(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract;

shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A), an individual breaches his or her written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(C) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Indian Tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary deems appropriate.

"(6) REQUIRED AGREEMENTS.—The recipient of a scholarship under paragraph (1) shall agree, in providing health care pursuant to the requirements of this subsection—

"(A) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made

pursuant to the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

"(B) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX of such Act to provide service to individuals entitled to medical assistance under the plan.

"(7) PAYMENTS.—The Secretary, through the area office, shall make payments under this subsection to an Indian Tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary or area office determines that, for the immediately preceding fiscal year, the Indian Tribe or tribal organization has not complied with the requirements of this subsection.

"SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

"(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds to at least 3 colleges and

universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various colleges and universities throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

"(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.—The Secretary shall provide funds under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115, the Quentin N. Burdick Indians into Health Program authorized under section 117, and existing university research and communications networks.

"(c) REQUIREMENTS.—

"(1) REGULATIONS.—The Secretary shall promulgate regulations pursuant to this Act for the competitive awarding of funds under this section.

"(2) PROGRAM.—Applicants for funds under this section shall agree to provide a program which, at a minimum—

"(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and accredited and accessible community colleges that will be served by the program;

"(B) incorporates a program advisory board comprised of representatives from the Tribes and communities that will be served by the program;

"(C) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

"(D) provides stipends to undergraduate and graduate students to pursue a career in psychology;

"(E) develops affiliation agreements with tribal community colleges, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

"(F) utilizes, to the maximum extent feasible, existing university tutoring, counseling and student support services; and

"(G) employs, to the maximum extent feasible, qualified Indians in the program.

"(d) ACTIVE DUTY OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

"(1) in the Indian Health Service;

"(2) in a program conducted under a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act;

"(3) in a program assisted under title V; or

"(4) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to

employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship.

"(b) ENROLLEES IN COURSE OF STUDY.—Any individual who is enrolled in a course of study in the health professions may be employed by the Service or by an Indian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(c) HIGH SCHOOL PROGRAMS.—Any individual who is in a high school program authorized under section 103(a) may be employed by the Service, or by a Indian Tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(d) ADMINISTRATIVE PROVISIONS.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency per-

sonnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

"SEC. 108. CONTINUING EDUCATION ALLOWANCES.

"In order to encourage health professionals, including for purposes of this section, community health representatives and emergency medical technicians, to join or continue in the Service or in any program of an Indian tribe, tribal organization, or urban Indian organization and to provide their services in the rural and remote areas where a significant portion of the Indian people reside, the Secretary, acting through the area offices, may provide allowances to health professionals employed in the Service or such a program to enable such professionals to take leave of their duty stations for a period of time each year (as prescribed by regulations of the Secretary) for professional consultation and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall maintain a Community Health Representative Program under which the Service, Indian tribes and tribal organizations—

"(1) provide for the training of Indians as community health representatives; and

"(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Representative Program, shall—

"(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such Program;

"(2) in order to provide such training, develop and maintain a curriculum that—

"(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

"(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

"(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and maintain programs that meet the needs for such continuing education;

"(4) maintain a system that provides close supervision of community health representatives;

"(5) maintain a system under which the work of community health representatives is reviewed and evaluated; and

"(6) promote traditional health care practices of the Indian tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

"SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall establish a program to be

known as the Indian Health Service Loan Repayment Program (referred to in this Act as the 'Loan Repayment Program') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

"(2) DEFINITIONS.—In this section:

"(A) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

"(i) directly by the Service;

"(ii) by any Indian tribe or tribal or Indian organization pursuant to a funding agreement under—

"(I) the Indian Self-Determination and Educational Assistance Act; or

"(II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47) (commonly known as the 'Buy-Indian Act'); or

"(iii) by an urban Indian organization pursuant to title V.

"(B) STATE.—The term 'State' has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.

"(b) ELIGIBILITY.—To be eligible to participate in the Loan Repayment Program, an individual must—

"(1)(A) be enrolled—

"(i) in a course of study or program in an accredited institution, as determined by the Secretary, within any State and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

"(ii) in an approved graduate training program in a health profession; or

"(B) have—

"(i) a degree in a health profession; and

"(ii) a license to practice a health profession in a State;

"(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

"(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

"(C) meet the professional standards for civil service employment in the Indian Health Service; or

"(D) be employed in an Indian health program without a service obligation; and

"(3) submit to the Secretary an application for a contract described in subsection (f).

"(c) FORMS.—

"(1) IN GENERAL.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Indian Health

Service to enable the individual to make a decision on an informed basis.

"(2) FORMS TO BE UNDERSTANDABLE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

"(3) AVAILABILITY.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

"(d) PRIORITY.—

"(1) ANNUAL DETERMINATIONS.—The Secretary, acting through the Service and in accordance with subsection (k), shall annually—

"(A) identify the positions in each Indian health program for which there is a need or a vacancy; and

"(B) rank those positions in order of priority.

"(2) PRIORITY IN APPROVAL.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall give priority to applications made by—

"(A) Indians; and

"(B) individuals recruited through the efforts an Indian tribe, tribal organization, or urban Indian organization.

"(e) CONTRACTS.—

"(1) IN GENERAL.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

"(2) NOTICE.—Not later than 21 days after considering an individual for participation in the Loan Repayment Program under paragraph (1), the Secretary shall provide written notice to the individual of—

"(A) the Secretary's approving of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

"(B) the Secretary's disapproving an individual's participation in such Program.

"(f) WRITTEN CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

"(1) an agreement under which—

"(A) subject to paragraph (3), the Secretary agrees—

"(i) to pay loans on behalf of the individual in accordance with the provisions of this section; and

"(ii) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a tribe, tribal organization, or urban Indian organization as provided in subparagraph (B)(iii); and

"(B) subject to paragraph (3), the individual agrees—

"(i) to accept loan payments on behalf of the individual;

"(ii) in the case of an individual described in subsection (b)(1)—

"(I) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

"(II) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training);

"(iii) to serve for a time period (referred to in this section as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary;

"(2) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under paragraph (1)(B)(iii);

"(3) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

"(4) a statement of the damages to which the United States is entitled under subsection (l) for the individual's breach of the contract; and

"(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

"(g) LOAN REPAYMENTS.—

"(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

"(A) tuition expenses;

"(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

"(C) reasonable living expenses as determined by the Secretary.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act) on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

"(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

"(ii) provides an incentive to serve in Indian health programs with the greatest shortages of health professionals; and

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

"(B) TIME FOR PAYMENT.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made not later than the end of the fiscal year in which the individual completes such year of service.

"(3) SCHEDULE FOR PAYMENTS.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

"(h) COUNTING OF INDIVIDUALS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be

counted against any employment ceiling affecting the Department.

"(i) RECRUITING PROGRAMS.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other health professional programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

"(j) NONAPPLICATION OF CERTAIN PROVISION.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

"(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian health programs pursuant to contracts entered into under this section, shall—

"(1) ensure that the staffing needs of Indian health programs administered by an Indian tribe or tribal or health organization receive consideration on an equal basis with programs that are administered directly by the Service; and

"(2) give priority to assigning individuals to Indian health programs that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

"(l) BREACH OF CONTRACT.—

"(1) IN GENERAL.—An individual who has entered into a written contract with the Secretary under this section and who—

"(A) is enrolled in the final year of a course of study and who—

"(i) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) voluntarily terminates such enrollment; or

"(iii) is dismissed from such educational institution before completion of such course of study; or

"(B) is enrolled in a graduate training program, and who fails to complete such training program, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii),

shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.

"(2) AMOUNT OF RECOVERY.—If, for any reason not specified in paragraph (1), an individual breaches his written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (f), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula:

$$A=3Z(t-s/t)$$

in which—

"(A) 'A' is the amount the United States is entitled to recover;

"(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

"(C) 't' is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

"(D) 's' is the number of months of such period served by such individual in accordance with this section.

Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

"(3) DAMAGES.—

"(A) TIME FOR PAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach of contract or such longer period beginning on such date as shall be specified by the Secretary.

"(B) DELINQUENCIES.—If damages described in subparagraph (A) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

"(i) utilize collection agencies contracted with by the Administrator of the General Services Administration; or

"(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

"(C) CONTRACTS FOR RECOVERY OF DAMAGES.—Each contract for recovering damages pursuant to this subsection shall provide that

the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

"(m) CANCELLATION, WAIVER OR RELEASE.—

"(1) CANCELLATION.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

"(2) WAIVER OF SERVICE OBLIGATION.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(3) WAIVER OF RIGHTS OF UNITED STATES.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship

or other good cause shown, as determined by the Secretary.

"(4) RELEASE.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

"(n) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be submitted to the Congress under section 801, a report concerning the previous fiscal year which sets forth—

"(1) the health professional positions maintained by the Service or by tribal or Indian organizations for which recruitment or retention is difficult;

"(2) the number of Loan Repayment Program applications filed with respect to each type of health profession;

"(3) the number of contracts described in subsection (f) that are entered into with respect to each health profession;

"(4) the amount of loan payments made under this section, in total and by health profession;

"(5) the number of scholarship grants that are provided under section 105 with respect to each health profession;

"(6) the amount of scholarship grants provided under section 105, in total and by health profession;

"(7) the number of providers of health care that will be needed by Indian health programs, by location and profession, during the 3 fiscal years beginning after the date the report is filed; and

"(8) the measures the Secretary plans to take to fill the health professional positions maintained by the Service or by tribes, tribal organizations, or urban Indian organizations for which recruitment or retention is difficult.

"SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

"(a) ESTABLISHMENT.—Notwithstanding section 102, there is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

"(1) such amounts as may be collected from individuals under subparagraphs (A) and (B) of section 105(b)(4) and section 110(l) for breach of contract;

"(2) such funds as may be appropriated to the LRRF;

"(3) such interest earned on amounts in the LRRF; and

"(4) such additional amounts as may be collected, appropriated, or earned relative to the LRRF.

Amounts appropriated to the LRRF shall remain available until expended.

"(b) USE OF LRRF.—

"(1) IN GENERAL.—Amounts in the LRRF may be expended by the Secretary, subject to section 102, acting through the Service, to make payments to the Service or to an Indian tribe or tribal organization administering a health care program pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act—

"(A) to which a scholarship recipient under section 105 or a loan repayment program participant under section 110 has been assigned to

meet the obligated service requirements pursuant to sections; and

"(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 105 or section 110.

"(2) SCHOLARSHIPS AND RECRUITING.—An Indian tribe or tribal organization receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or to recruit and employ, directly or by contract, health professionals to provide health care services.

"(c) INVESTING OF FUND.—

"(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

"(2) SALE PRICE.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

"SEC. 112. RECRUITMENT ACTIVITIES.

"(a) REIMBURSEMENT OF EXPENSES.—The Secretary may reimburse health professionals seeking positions in the Service, Indian tribes, tribal organizations, or urban Indian organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

"(b) ASSIGNMENT OF PERSONNEL.—The Secretary, acting through the Service, shall assign one individual in each area office to be responsible on a full-time basis for recruitment activities.

"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

"(a) FUNDING OF PROJECTS.—The Secretary, acting through the Service, shall fund innovative projects for a period not to exceed 3 years to enable Indian tribes, tribal organizations, and urban Indian organizations to recruit, place, and retain health professionals to meet the staffing

needs of Indian health programs (as defined in section 110(a)(2)(A)).

"(b) ELIGIBILITY.—Any Indian tribe, tribal organization, or urban Indian organization may submit an application for funding of a project pursuant to this section.

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

"(a) DEMONSTRATION PROJECT.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian health program (as defined in section 110) for a substantial period of time to pursue advanced training or research in areas of study for which the Secretary determines a need exists.

"(b) SERVICE OBLIGATION.—

"(1) IN GENERAL.—An individual who participates in the project under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to at least the period of time during which the individual participates in such project.

"(2) FAILURE TO COMPLETE SERVICE.—In the event that an individual fails to complete a period of obligated service under paragraph (1), the individual shall be liable to the United States for the period of

service remaining. In such event, with respect to individuals entering the project after the date of the enactment of this Act, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(c) OPPORTUNITY TO PARTICIPATE.—Health professionals from Indian tribes, tribal organizations, and urban Indian organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to participate in the program under subsection (a).

"SEC. 115. NURSING PROGRAMS; QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

"(a) GRANTS.—Notwithstanding section 102, the Secretary, acting through the Service, shall provide funds to—

"(1) public or private schools of nursing;

"(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) nurse midwife programs, and advance practice nurse programs, that are provided by any tribal college accredited nursing program, or in the absence of such, any other public or private institution,

for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians.

"(b) USE OF GRANTS.—Funds provided under subsection (a) may be used to—

"(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses;

"(2) provide scholarships to Indian individuals enrolled in such programs that may be used to pay the tuition charged for such program and for other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses;

"(3) provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians;

"(4) provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses; or

"(5) provide any program that is designed to achieve the purpose described in subsection (a).

"(c) APPLICATIONS.—Each application for funds under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

"(d) PREFERENCES.—In providing funds under subsection (a), the Secretary shall extend a preference to—

"(1) programs that provide a preference to Indians;

"(2) programs that train nurse midwives or advanced practice nurses;

"(3) programs that are interdisciplinary; and

"(4) programs that are conducted in cooperation with a center for gifted and talented Indian students established under section 5324(a) of the Indian Education Act of 1988.

"(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available to establish and maintain a program at the

University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

"(f) SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) that is funded under subsection (a). Such obligation shall be met by service—

"(1) in the Indian Health Service;

"(2) in a program conducted under a contract entered into under the Indian Self-Determination and Education assistance Act;

"(3) in a program assisted under title V; or

"(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"SEC. 116. TRIBAL CULTURE AND HISTORY.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian tribes in each service area receive educational instruction in the history and culture of such tribes and their relationship to the Service.

"(b) REQUIREMENTS.—To the extent feasible, the educational instruction to be provided under subsection (a) shall—

"(1) be provided in consultation with the affected tribal governments, tribal organizations, and urban Indian organizations;

"(2) be provided through tribally-controlled community colleges (within the meaning of section 2(4) of the Tribally Controlled Community College Assistance Act of 1978) and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) include instruction in Native American studies.

"SEC. 117. INMED PROGRAM.

"(a) GRANTS.—The Secretary may provide grants to 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruit-

ment program known as the 'Indians into Medicine Program' (referred to in this section as 'INMED') as a means of encouraging Indians to enter the health professions.

"(b) QUENTIN N. BURDICK INDIAN HEALTH PROGRAM.—The Secretary shall provide 1 of the grants under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

"(c) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall develop regulations to govern grants under to this section.

"(2) PROGRAM REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program that—

"(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community

colleges located on Indian reservations which will be served by the program;

"(B) incorporates a program advisory board comprised of representatives from the tribes and communities which will be served by the program;

"(C) provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions;

"(D) provides tutoring, counseling and support to students who are enrolled in a health career program of study at the respective college or university; and

"(E) to the maximum extent feasible, employs qualified Indians in the program.

"SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

"(a) ESTABLISHMENT GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health pro-

fession for individuals who desire to practice such profession on an Indian reservation, in the Service, or in a tribal health program.

"(2) AMOUNT.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $100,000.

"(b) CONTINUATION GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

"(2) ELIGIBILITY.—Grants may only be made under this subsection to a community college that—

"(A) is accredited;

"(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

"(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

"(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

"(ii) stipulate certifications necessary to approve internship and field placement opportunities at health programs of the Service or at tribal health programs;

"(D) has a qualified staff which has the appropriate certifications;

"(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

"(F) agrees to provide for Indian preference for applicants for programs under this section.

"(c) SERVICE PERSONNEL AND TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

"(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs, and

"(2) providing technical assistance and support to such colleges.

"(d) SPECIFIED COURSES OF STUDY.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

"(1) has already received a degree or diploma in such health profession; and

"(2) provides clinical services on an Indian reservation, at a Service facility, or at a tribal clinic.

Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

"(e) PRIORITY.—Priority shall be provided under this section to tribally controlled colleges in service areas that meet the requirements of subsection (b).

"(f) DEFINITIONS.—In this section:

"(1) COMMUNITY COLLEGE.—The term 'community college' means—

"(A) a tribally controlled community college; or

"(B) a junior or community college.

"(2) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college" has the meaning given such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

"(3) TRIBALLY CONTROLLED COLLEGE.—The term 'tribally controlled college' has the meaning given the term 'tribally controlled community college' by section 2(4) of the Tribally Controlled Community College Assistance Act of 1978.

"SEC. 119. RETENTION BONUS.

"(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

"(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

"(2) the Secretary determines is needed by the Service, tribe, tribal organization, or urban organization;

"(3) has—

"(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban organization; or

"(B) completed any service obligations incurred as a requirement of—

"(i) any Federal scholarship program; or

"(ii) any Federal education loan repayment program; and

"(4) enters into an agreement with the Service, Indian tribe, tribal organization, or urban Indian organization for continued employment for a period of not less than 1 year.

"(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

"(c) FAILURE TO COMPLETE TERM OF SERVICE.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as

determined by the Secretary in accordance with section 110(l)(2)(B).

"(d) FUNDING AGREEMENT.—The Secretary may pay a retention bonus to any health professional employed by an organization providing health care services to Indians pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act if such health professional is serving in a position which the Secretary determines is—

"(1) a position for which recruitment or retention is difficult; and

"(2) necessary for providing health care services to Indians.

"SEC. 120. NURSING RESIDENCY PROGRAM.

"(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 110(a)(2)(A)), and have done so for a period of not less than 1 year, to pursue advanced training.

"(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) leading to an associate

or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse) or an advanced degrees in nursing and public health.

"(c) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13; commonly known as the Snyder Act), the Secretary shall maintain a Community Health Aide Program in Alaska under which the Service—

"(1) provides for the training of Alaska Natives as health aides or community health practitioners;

"(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

"(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Aide Program under subsection (a), shall—

"(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

"(2) in order to provide such training, develop a curriculum that—

"(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

"(B) provides instruction and practical experience in the provision of acute care, emer-

gency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

"(C) promotes the achievement of the health status objective specified in section 3(b);

"(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or who can demonstrate equivalent experience;

"(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

"(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

"(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the pro-

vision of quality health care, health promotion, and disease prevention services.

"SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

"Subject to Section 102, the Secretary, acting through the Service, shall, through a funding agreement or otherwise, provide training for Indians in the administration and planning of tribal health programs.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROJECT.

"(a) PILOT PROGRAMS.—The Secretary may, through area offices, fund pilot programs for tribes and tribal organizations to address chronic shortages of health professionals.

"(b) PURPOSE.—It is the purpose of the health professions demonstration project under this section to—

"(1) provide direct clinical and practical experience in a service area to health professions students and residents from medical schools;

"(2) improve the quality of health care for Indians by assuring access to qualified health care professionals; and

"(3) provide academic and scholarly opportunities for health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

"(c) ADVISORY BOARD.—A pilot program established under subsection (a) shall incorporate a program advisory board that shall be composed of representatives from the tribes and communities in the service area that will be served by the program.

"SEC. 124. SCHOLARSHIPS.

"Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'qualified scholarships' for purposes of section 117 of the Internal Revenue Code of 1986.

"SEC. 125. NATIONAL HEALTH SERVICE CORPS.

"(a) LIMITATIONS.—The Secretary shall not—

"(1) remove a member of the National Health Services Corps from a health program operated by Indian Health Service or by a tribe or tribal organization under a funding agreement with the Service under the Indian Self-Determination and Education Assistance Act, or by urban Indian organizations; or

"(2) withdraw the funding used to support such a member;

unless the Secretary, acting through the Service, tribes or tribal organization, has ensured that the Indians receiving services from such member will experience no reduction in services.

"(b) DESIGNATION OF SERVICE AREAS AS HEALTH PROFESSIONAL SHORTAGE AREAS.—All service areas served by programs operated by the Service or by a tribe or tribal organization sunder the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization, shall be designated under section 332 of the Public Health Service Act (42 U.S.C. 254e) as Health Professional Shortage Areas.

"(c) FULL TIME EQUIVALENT.—National Health Service Corps scholars that qualify for the commissioned corps in the Public Health Service shall be exempt from the full time equivalent limitations of the National Health Service Corps and the Service when such scholars serve as commissioned corps officers in a health program operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization.

"SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT.

"(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible commu-

nity colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

"(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

"(c) TERM OF GRANT.—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1 year period upon the approval of the Secretary.

"(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

"(e) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

"(f) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.

"(g) DEFINITIONS.—In this section:

"(1) EDUCATIONAL CURRICULUM.—The term 'educational curriculum' means 1 or more of the following:

"(A) Classroom education.

"(B) Clinical work experience.

"(C) Continuing education workshops.

"(2) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' has the meaning given such term in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

"(3) TRIBALLY CONTROLLED POSTSECONDARY VOCATIONAL INSTITUTION.—The term 'tribally controlled postsecondary vocational institution' has the meaning given such term in section 390(2) of the

Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)).

"SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION.

"(a) STUDY AND LIST.—

"(1) IN GENERAL.—The Secretary and the Secretary of the Interior in consultation with Indian tribes and tribal organizations shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include or should include, training in the identification, prevention, education, referral or treatment of mental illness, dysfunctional or self-destructive behavior.

"(2) POSITIONS.—The positions referred to in paragraph (1) are—

"(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

"(i) elementary and secondary education;

"(ii) social services, family and child welfare;

"(iii) law enforcement and judicial services; and

"(iv) alcohol and substance abuse;

"(B) staff positions within the Service; and

"(C) staff positions similar to those specified in subsection (b) and established and maintained by Indian tribes, tribal organizations, and urban Indian organizations, including positions established pursuant to funding agreements under the Indian Self-determination and Education Assistance Act, and this Act.

"(3) TRAINING CRITERIA.—

"(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position specified in subsection (b)(1) and ensure that appropriate training has been or will be provided to any individual in any such position.

"(B) TRAINING.—With respect to any such individual in a position specified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training or provide funds to an Indian tribe, tribal organization, or urban Indian organization for the training of appropriate individuals. In the case of a funding agreement, the appropriate Secretary shall

ensure that such training costs are included in the funding agreement, if necessary.

"(4) CULTURAL RELEVANCY.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

"(5) COMMUNITY EDUCATION.—

"(A) DEVELOPMENT.—The Service shall develop and implement, or on request of an Indian tribe or tribal organization, assist an Indian tribe or tribal organization, in developing and implementing a program of community education on mental illness.

"(B) TECHNICAL ASSISTANCE.—In carrying out this paragraph, the Service shall, upon the request of an Indian tribe or tribal organization, provide technical assistance to the Indian tribe or tribal organization to obtain and develop community educational materials on the identification, prevention, referral and treatment of mental illness, dysfunctional and self-destructive behavior.

"(b) STAFFING.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of the Act, the Director of the Service shall develop a plan under which the Service will increase the number of health care staff that are providing mental health services by at least 500 positions within 5 years after such date of enactment, with at least 200 of such positions devoted to child, adolescent, and family services. The allocation of such positions shall be subject to the provisions of section 102(a).

"(2) IMPLEMENTATION.—The plan developed under paragraph (1) shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly know as the 'Snyder Act').

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

"(a) IN GENERAL.—The Secretary may expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, that are appropriated under the authority of this section, for the purposes of—

"(1) eliminating the deficiencies in the health status and resources of all Indian tribes;

"(2) eliminating backlogs in the provision of health care services to Indians;

"(3) meeting the health needs of Indians in an efficient and equitable manner;

"(4) eliminating inequities in funding for both direct care and contract health service programs; and –

"(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status and resource deficiencies:

"(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

"(B) preventive health, including mammography and other cancer screening in accordance with section 207;

"(C) dental care;

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers,

and training of traditional health care practitioners;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

"(G) accident prevention programs;

"(H) home health care;

"(I) community health representatives;

"(J) maintenance and repair; and

"(K) traditional health care practices.

"(b) USE OF FUNDS.—

"(1) LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act, the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

"(2) ALLOCATION.—

"(A) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to service units or Indian tribes or tribal organizations. The funds allocated to each tribe, tribal organization, or service unit under this

subparagraph shall be used to improve the health status and reduce the resource deficiency of each tribe served by such service unit, tribe or tribal organization.

"(B) APPORTIONMENT.—The apportionment of funds allocated to a service unit, tribe or tribal organization under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes in accordance with this section and such rules as may be established under title VIII.

"(c) HEALTH STATUS AND RESOURCE DEFICIENCY.—In this section:

"(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

"(A) the health status objective set forth in section 3(2) is not being achieved; and

"(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local

geographic, climatic, rural, or other circumstances.

"(2) RESOURCES.—The health resources available to an Indian tribe or tribal organization shall include health resources provided by the Service as well as health resources used by the Indian Tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

"(3) REVIEW OF DETERMINATION.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such tribe or tribal organization.

"(d) ELIGIBILITY.—Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

"(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit to the Congress the current health sta-

tus and resource deficiency report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

"(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

"(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service;

"(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service; and

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service, for the preceding fiscal year which is allocated to each service unit, Indian tribe, or comparable entity;

"(B) the number of Indians eligible for health services in each service unit or Indian tribe or tribal organization; and

"(C) the number of Indians using the Service resources made available to each service

unit or Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

"(f) BUDGETARY RULE.—Funds appropriated under the authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs or to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

"(h) DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

"SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby established an Indian Catastrophic Health Emergency Fund (referred to in this section as the 'CHEF') consisting of—

"(A) the amounts deposited under subsection (d); and

"(B) any amounts appropriated to the CHEF under this Act.

"(2) ADMINISTRATION.—The CHEF shall be administered by the Secretary solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

"(3) EQUITABLE ALLOCATION.—The CHEF shall be equitably allocated, apportioned or delegated on a service unit or area office basis, based upon a formula to be developed by the Secretary in consultation with the Indian tribes and tribal organizations through negotiated rulemaking under title VIII. Such formula shall take into account the added needs of service areas which are contract health service dependent.

"(4) NOT SUBJECT TO CONTRACT OR GRANT.—No part of the CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

"(5) ADMINISTRATION.—Amounts provided from the CHEF shall be administered by the area offices based upon priorities determined by the Indian tribes and tribal organizations within each service area, including a consideration of the needs of Indian tribes and tribal organizations which are contract health service-dependent.

"(b) REQUIREMENTS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section—

"(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the CHEF;

"(2) provide that a service unit, Indian tribe, or tribal organization shall not be eligible for reimbursement for the cost of treatment from the CHEF until its cost of treatment for any victim of such a catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

"(A) for 1999, not less than $19,000; and

"(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

"(3) establish a procedure for the reimbursement of the portion of the costs incurred by—

"(A) service units, Indian tribes, or tribal organizations, or facilities of the Service; or

"(B) non-Service facilities or providers whenever otherwise authorized by the Service;

in rendering treatment that exceeds threshold cost described in paragraph (2);

"(4) establish a procedure for payment from the CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(5) establish a procedure that will ensure that no payment shall be made from the CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private

source of reimbursement for which the patient is eligible.

"(c) LIMITATION.—Amounts appropriated to the CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act) or any other law.

"(d) DEPOSITS.—There shall be deposited into the CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from the CHEF.

"SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

"(a) FINDINGS.—Congress finds that health promotion and disease prevention activities will——

"(1) improve the health and well-being of Indians; and

"(2) reduce the expenses for health care of Indians.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and through Indian tribes and tribal organizations, shall provide health promotion and

disease prevention services to Indians so as to achieve the health status objective set forth in section 3(b).

"(c) DISEASE PREVENTION AND HEALTH PROMOTION.—In this section:

"(1) DISEASE PREVENTION.—The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications, and the reduction in the consequences of such diseases, including—

"(A) controlling—

"(i) diabetes;

"(ii) high blood pressure;

"(iii) infectious agents;

"(iv) injuries;

"(v) occupational hazards and disabilities;

"(vi) sexually transmittable diseases; and

"(vii) toxic agents; and

"(B) providing—

"(i) for the fluoridation of water; and

"(ii) immunizations.

"(2) HEALTH PROMOTION.—The term 'health promotion' means fostering social, economic, envi-

ronmental, and personal factors conducive to health, including—

"(A) raising people's awareness about health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information;

"(B) encouraging adequate and appropriate diet, exercise, and sleep;

"(C) promoting education and work in conformity with physical and mental capacity;

"(E) making available suitable housing, safe water, and sanitary facilities;

"(F) improving the physical economic, cultural, psychological, and social environment;

"(G) promoting adequate opportunity for spiritual, religious, and traditional practices; and

"(H) adequate and appropriate programs including—

"(i) abuse prevention (mental and physical);

"(iii) community health;

"(iv) community safety;

"(v) consumer health education;

"(vi) diet and nutrition;

"(vii) disease prevention (communicable, immunizations, HIV/AIDS);

"(viii) environmental health;

"(ix) exercise and physical fitness;

"(x) fetal alcohol disorders;

"(xi) first aid and CPR education;

"(xii) human growth and development;

"(xiii) injury prevention and personal safety;

"(xiv) mental health (emotional, self-worth);

"(xv) personal health and wellness practices;

"(xvi) personal capacity building;

"(xvii) prenatal, pregnancy, and infant care;

"(xviii) psychological well being;

"(xix) reproductive health (family planning);

"(xx) safe and adequate water;

"(xxi) safe housing;

"(xxii) safe work environments;

"(xxiii) stress control;

"(xxiv) substance abuse;

"(xxv) sanitary facilities;

"(xxvi) tobacco use cessation and reduction;

"(xxvii) violence prevention; and

"(xxviii) such other activities identified by the Service, an Indian tribe or tribal organization, to promote the achievement of the objective described in section 3(b).

"(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement which is required to be submitted to Congress under section 801 an evaluation of—

"(1) the health promotion and disease prevention needs of Indians;

"(2) the health promotion and disease prevention activities which would best meet such needs;

"(3) the internal capacity of the Service to meet such needs; and

"(4) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs.

"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

"(a) DETERMINATION.—The Secretary, in consultation with Indian tribes and tribal organizations, shall determine—

"(1) by tribe, tribal organization, and service unit of the Service, the prevalence of, and the types of complications resulting from, diabetes among Indians; and

"(2) based on paragraph (1), the measures (including patient education) each service unit should take to reduce the prevalence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that service unit.

"(b) SCREENING.—The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by an Indian tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act.

"(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2012, each effective model diabetes project in existence on the date of the enactment of this Act and such other diabetes programs op-

erated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.

"(d) DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian tribes and tribal organizations to establish dialysis programs, including funds to purchase dialysis equipment and provide necessary staffing.

"(e) OTHER ACTIVITIES.—The Secretary shall, to the extent funding is available—

"(1) in each area office of the Service, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

"(2) establish in each area office of the Service a registry of patients with diabetes to track the prevalence of diabetes and the complications from diabetes in that area; and

"(3) ensure that data collected in each area office regarding diabetes and related complications

among Indians is disseminated to tribes, tribal organizations, and all other area offices.

"SEC. 205. SHARED SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into funding agreements or other arrangements with Indian tribes or tribal organizations for the delivery of long-term care and similar services to Indians. Such projects shall provide for the sharing of staff or other services between a Service or tribal facility and a long-term care or other similar facility owned and operated (directly or through a funding agreement) by such Indian tribe or tribal organization.

"(b) REQUIREMENTS.—A funding agreement or other arrangement entered into pursuant to subsection (a)—

"(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

"(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal facility be allocated propor-

tionately between the Service and the tribe or tribal organization; and

"(3) may authorize such tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

"(c) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

"(d) USE OF EXISTING FACILITIES.—The Secretary shall encourage the use for long-term or similar care of existing facilities that are under-utilized or allow the use of swing beds for such purposes.

"SEC. 206. HEALTH SERVICES RESEARCH.

"(a) FUNDING.—The Secretary shall make funding available for research to further the performance of the health service responsibilities of the Service, Indian tribes, and tribal organizations and shall coordinate the activities of other Agencies within the Department to address these research needs.

"(b) ALLOCATION.—Funding under subsection (a) shall be allocated equitably among the area offices. Each area office shall award such funds competitively within that area.

"(c) ELIGIBILITY FOR FUNDS.—Indian tribes and tribal organizations receiving funding from the Service under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

"(d) USE.—Funds received under this section may be used for both clinical and non-clinical research by Indian tribes and tribal organizations and shall be distributed to the area offices. Such area offices may make grants using such funds within each area.

"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

"The Secretary, through the Service or through Indian tribes or tribal organizations, shall provide for the following screening:

"(1) Mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act.

"(2) Other cancer screening meeting national standards.

"SEC. 208. PATIENT TRAVEL COSTS.

"The Secretary, acting through the Service, Indian tribes and tribal organizations shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving health care services provided (either through direct or contract care or through funding agreements entered into pursuant to the Indian Self-Determination and Education Assistance Act) under this Act:

"(1) Emergency air transportation and non-emergency air transportation where ground transportation is infeasible.

"(2) Transportation by private vehicle, specially equipped vehicle and ambulance.

"(3) Transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

"SEC. 209. EPIDEMIOLOGY CENTERS.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this Act, (including those centers for which funding is currently being provided through funding agree-

ments under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in paragraph (2). Any centers established under the preceding sentence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

"(2) FUNCTIONS.—In consultation with and upon the request of Indian tribes, tribal organizations and urban Indian organizations, each area epidemiology center established under this subsection shall, with respect to such area shall—

"(A) collect data related to the health status objective described in section 3(b), and monitor the progress that the Service, Indian tribes, tribal organizations, and urban Indian organizations have made in meeting such health status objective;

"(B) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

"(C) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

"(D) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities;

"(E) make recommendations to improve health care delivery systems for Indians and urban Indians;

"(F) provide requested technical assistance to Indian Tribes and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

"(G) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian organizations to promote public health.

"(3) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall

provide technical assistance to the centers in carrying out the requirements of this subsection.

"(b) FUNDING.—The Secretary may make funding available to Indian tribes, tribal organizations, and eligible intertribal consortia or urban Indian organizations to conduct epidemiological studies of Indian communities.

"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide funding to Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and urban Indian children.

"(b) USE OF FUNDS.—Funds awarded under this section may be used to—

"(1) develop and implement health education curricula both for regular school programs and after school programs;

"(2) train teachers in comprehensive school health education curricula;

"(3) integrate school-based, community-based, and other public and private health promotion efforts;

"(4) encourage healthy, tobacco-free school environments;

"(5) coordinate school-based health programs with existing services and programs available in the community;

"(6) develop school programs on nutrition education, personal health, oral health, and fitness;

"(7) develop mental health wellness programs;

"(8) develop chronic disease prevention programs;

"(9) develop substance abuse prevention programs;

"(10) develop injury prevention and safety education programs;

"(11) develop activities for the prevention and control of communicable diseases;

"(12) develop community and environmental health education programs that include traditional health care practitioners;

"(13) carry out violence prevention activities; and

"(14) carry out activities relating to such other health issues as are appropriate.

"(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian tribes,

tribal organization and urban Indian organizations in the development of comprehensive health education plans, and the dissemination of comprehensive health education materials and information on existing health programs and resources.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes tribal organizations, and urban Indian organizations shall establish criteria for the review and approval of applications for funding under this section.

"(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

"(1) DEVELOPMENT.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary and affected Indian tribes and tribal organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 for use in schools operated by the Bureau of Indian Affairs.

"(2) REQUIREMENTS.—The program developed under paragraph (1) shall include—

"(A) school programs on nutrition education, personal health, oral health, and fitness;

"(B) mental health wellness programs;

"(C) chronic disease prevention programs;

"(D) substance abuse prevention programs;

"(E) injury prevention and safety education programs; and

"(F) activities for the prevention and control of communicable diseases.

"(3) TRAINING AND COORDINATION.—The Secretary of the Interior shall—

"(A) provide training to teachers in comprehensive school health education curricula;

"(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

"(C) encourage healthy, tobacco-free school environments.

"SEC. 211. INDIAN YOUTH PROGRAM.

"(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to provide funding to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—Funds made available under this section may be used to—

"(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

"(B) develop and provide community training and education.

"(2) LIMITATION.—Funds made available under this section may not be used to provide services described in section 707(c).

"(c) REQUIREMENTS.—The Secretary shall—

"(1) disseminate to Indian tribes, tribal organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

"(2) encourage the implementation of such models; and

"(3) at the request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance in the implementation of such models.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes, tribal organization, and urban Indian organizations, shall establish criteria for the review and approval of applications under this section.

"SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

"(a) IN GENERAL.—The Secretary, acting through the Service after consultation with Indian tribes, tribal organizations, urban Indian organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian tribes and tribal organizations for—

"(1) projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori;

"(2) public information and education programs for the prevention, control, and elimination of communicable and infectious diseases; and

"(3) education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

"(b) REQUIREMENT OF APPLICATION.—The Secretary may provide funds under subsection (a) only if an application or proposal for such funds is submitted.

"(c) TECHNICAL ASSISTANCE AND REPORT.—In carrying out this section, the Secretary—

"(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

"(2) shall prepare and submit, biennially, a report to Congress on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.

"SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objective set forth in section 3 through health care related services and programs not otherwise described in this Act. Such services and programs shall include services and programs related to—

"(1) hospice care and assisted living;

"(2) long-term health care;

"(3) home- and community-based services;

"(4) public health functions; and

"(5) traditional health care practices.

"(b) AVAILABILITY OF SERVICES FOR CERTAIN INDIVIDUALS.—At the discretion of the Service, Indian tribe, or tribal organization, services hospice care, home health care (under section 201), home- and community-based care, assisted living, and long term care may be provided (on a cost basis) to individuals otherwise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to a tribe or tribal organization.

"(c) DEFINITIONS.—In this section:

"(1) HOME- AND COMMUNITY-BASED SERVICES.—The term 'home- and community-based services' means 1 or more of the following:

"(A) Homemaker/home health aide services.

"(B) Chore services.

"(C) Personal care services.

"(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

"(E) Training for family members.

"(F) Adult day care.

"(G) Such other home- and community-based services as the Secretary or a tribe or tribal organization may approve.

"(2) HOSPICE CARE.—The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of such care.

"(3) PUBLIC HEALTH FUNCTIONS.—The term 'public health functions' means public health related programs, functions, and services including assessments, assurances, and policy development that Indian tribes and tribal organizations are authorized and encouraged, in those circumstances where it meets their needs, to carry out by forming collaborative relationships with all levels of local, State, and Federal governments.

"SEC. 214. INDIAN WOMEN'S HEALTH CARE.

"The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs adminis-

tered by the Service, in order to improve and enhance the treatment models of care for Indian women.

"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

"(a) STUDY AND MONITORING PROGRAMS.—The Secretary and the Service shall, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and tribal organizations, conduct a study and carry out ongoing monitoring programs to determine the trends that exist in the health hazards posed to Indian miners and to Indians on or near Indian reservations and in Indian communities as a result of environmental hazards that may result in chronic or life-threatening health problems. Such hazards include nuclear resource development, petroleum contamination, and contamination of the water source or of the food chain. Such study (and any reports with respect to such study) shall include—

"(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

"(2) an analysis of the potential effect of ongoing and future environmental resource development on or near Indian reservations and communities in-

cluding the cumulative effect of such development over time on health;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal, oil and gas production or transportation on or near Indian reservations or communities, and other development that could affect the health of Indians and their water supply and food chain;

"(4) a summary of any findings or recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of this Act that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

"(5) a description of the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

"(b) DEVELOPMENT OF HEALTH CARE PLANS.—Upon the completion of the study under subsection (a), the Secretary and the Service shall take into account the results of such study and, in consultation with Indian tribes and tribal organizations, develop a health care plan to address the health problems that were the subject of such study. The plans shall include—

"(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

"(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

"(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

"(c) SUBMISSION TO CONGRESS.—

"(1) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Service shall submit to Congress

a report concerning the study conducted under subsection (a).

"(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address the health problems involved.

"(d) TASK FORCE.—

"(1) ESTABLISHED.—There is hereby established an Intergovernmental Task Force (referred to in this section as the 'task force') that shall be composed of the following individuals (or their designees):

"(A) The Secretary of Energy.

"(B) The Administrator of the Environmental Protection Agency.

"(C) The Director of the Bureau of Mines.

"(D) The Assistant Secretary for Occupational Safety and Health.

"(E) The Secretary of the Interior.

"(2) DUTIES.—The Task Force shall identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community, and enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

"(3) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

"(e) PROVISION OF APPROPRIATE MEDICAL CARE.—In the case of any Indian who—

"(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work related illness or condition;

"(2) is eligible to receive diagnosis and treatment services from a Service facility; and

"(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine

or mill operator or entity responsible for the environmental hazard;

the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

"SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2012, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a con-

tract health service delivery area pursuant to subsection (a).

"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM.

"(a) IN GENERAL.—The Secretary may fund a program that utilizes the California Rural Indian Health Board as a contract care intermediary to improve the accessibility of health services to California Indians.

"(b) REIMBURSEMENT OF BOARD.—

"(1) AGREEMENT.—The Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred pursuant to this section in providing medical treatment under contract to California Indians described in section 809(b) throughout the California contract health services delivery area described in section 218 with respect to high-cost contract care cases.

"(2) ADMINISTRATION.—Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be used for reimbursement for administrative expenses incurred by the Board during such fiscal year.

"(3) LIMITATION.—No payment may be made for treatment provided under this section to the ex-

tent that payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

"(c) ADVISORY BOARD.—There is hereby established an advisory board that shall advise the California Rural Indian Health Board in carrying out this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under this section, at least 50 percent of whom are not affiliated with the California Rural Indian Health Board.

"SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State, except that any of the counties described in this section may be included

in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

"(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

"The Service shall provide funds for health care programs and facilities operated by Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act on the same basis as such funds

are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

"Health care professionals employed by Indian Tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

"SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES.

"With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

"(a) REQUIREMENT.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

"(b) FAILURE TO RESPOND.—If the Service fails to respond to a notification of a claim in accordance with

subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

"(c) PAYMENT.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

"(a) NO LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

"(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services.

"(c) LIMITATION.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall have no further recourse against the patient who received the services involved.

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE III—FACILITIES

"SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

"(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

"(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

"(2) ensure, whenever practicable, that such facility meets the construction standards of any nationally recognized accrediting body by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURE OF FACILITIES.—

"(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by

the Service, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such proposed closure an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

"(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

"(B) the cost effectiveness of such closure;

"(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

"(D) the availability of contract health care funds to maintain existing levels of service;

"(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

"(F) the level of utilization of such hospital or facility by all eligible Indians; and

"(G) the distance between such hospital or facility and the nearest operating Service hospital.

"(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility

or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

"(c) PRIORITY SYSTEM.—

"(1) ESTABLISHMENT.—The Secretary shall establish a health care facility priority system, that shall—

"(A) be developed with Indian tribes and tribal organizations through negotiated rulemaking under section 802;

"(B) give the needs of Indian tribes' the highest priority; and

"(C) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E);

except that the priority of any project established under the construction priority system in effect on the date of this Act shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as one of the top 10 priority inpatient projects or one of the top 10 outpatient projects in the Indian Health Service budget justification for fiscal year 2000, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of this Act.

"(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report that includes—

"(A) a description of the health care facility priority system of the Service, as established under paragraph (1);

"(B) health care facility lists, including—

"(i) the total health care facility planning, design, construction and renovation needs for Indians;

"(ii) the 10 top-priority inpatient care facilities;

"(iii) the 10 top-priority outpatient care facilities;

"(iv) the 10 top-priority specialized care facilities (such as long-term care and alcohol and drug abuse treatment); and

"(v) any staff quarters associated with such prioritized facilities;

"(C) the justification for the order of priority among facilities;

"(D) the projected cost of the projects involved; and

"(E) the methodology adopted by the Service in establishing priorities under its health care facility priority system.

"(3) CONSULTATION.—In preparing each report required under paragraph (2) (other than the initial report) the Secretary shall annually—

"(A) consult with, and obtain information on all health care facilities needs from, Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act; and

"(B) review the total unmet needs of all tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

"(4) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluat-

ing the needs of facilities operated directly by the Service.

"(5) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities, operated under funding agreements in accordance with the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the health care facility priority system.

"(d) REVIEW OF NEED FOR FACILITIES.—

"(1) REPORT.—Beginning in 2001, the Secretary shall annually submit to the President, for inclusion in the report required to be transmitted to Congress under section 801 of this Act, a report which sets forth the needs of the Service and all Indian tribes and tribal organizations, including urban Indian organizations, for inpatient, outpatient and specialized care facilities, including the needs for renovation and expansion of existing facilities .

"(2) CONSULTATION.—In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into

with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

"(3) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

"(4) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of facilities operated under funding agreements, in accordance with the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the development of the health facility priority system.–

"(5) ANNUAL NOMINATIONS.—Each year the Secretary shall provide an opportunity for the nomination of planning, design, and construction projects by the Service and all Indian tribes and tribal organizations for consideration under the health care facility priority system.

"(e) INCLUSION OF CERTAIN PROGRAMS.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act.

"(f) INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes, tribal organizations and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

"SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

"(a) FINDINGS.—Congress finds and declares that—

"(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal facilities is primarily a health consideration and function;

"(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

"(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

"(4) many Indian homes and communities still lack safe water supply facilities and sanitary sewage and solid waste disposal facilities; and

"(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply facilities and sanitary sewage waste disposal facilities as soon as possible.

"(b) PROVISION OF FACILITIES AND SERVICES.—

"(1) IN GENERAL.—In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(2) ASSISTANCE.—The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

"(A) financial and technical assistance to Indian tribes, tribal organizations and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the tribe or tribal organization;

"(B) ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and

"(C) priority funding for the operation, and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

"(3) PROVISIONS RELATING TO FUNDING.—Notwithstanding any other provision of law—

"(A) the Secretary of Housing and Urban Development is authorized to transfer funds ap-

propriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

"(B) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

"(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

"(D) the Secretary of Health and Human Services is authorized to accept all Federal funds that are available for the purpose of providing sanitation facilities and related services and place those funds into funding agreements, authorized under the Indian Self-Determination and Education Assistance Act, between the Sec-

retary and Indian tribes and tribal organizations;

"(E) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to fund up to 100 percent of the amount of a tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

"(F) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

"(G) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned or appropriated and thereafter the Department's applicable policies, rules, regulations shall apply in the implementation of such projects;

"(H) the Secretary of Health and Human Services shall enter into inter-agency agree-

ments with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the Department of Agriculture, the Environmental Protection Agency and other appropriate Federal agencies, for the purpose of providing financial assistance for safe water supply and sanitary sewage disposal facilities under this Act; and

"(I) the Secretary of Health and Human Services shall, by regulation developed through rulemaking under section 802, establish standards applicable to the planning, design and construction of water supply and sanitary sewage and solid waste disposal facilities funded under this Act.

"(c) 10-YEAR FUNDING PLAN.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, shall develop and implement a 10-year funding plan to provide safe water supply and sanitary sewage and solid waste disposal facilities serving existing Indian homes and communities, and to new and renovated Indian homes.

"(d) CAPABILITY OF TRIBE OR COMMUNITY.—The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation fa-

cility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

"(e) FINANCIAL ASSISTANCE.—The Secretary may provide financial assistance to Indian tribes, tribal organizations and communities for the operation, management, and maintenance of their sanitation facilities.

"(f) RESPONSIBILITY FOR FEES FOR OPERATION AND MAINTENANCE.—The Indian family, community or tribe involved shall have the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities. If a community facility is threatened with imminent failure and there is a lack of tribal capacity to maintain the integrity or the health benefit of the facility, the Secretary may assist the Tribe in the resolution of the problem on a short term basis through cooperation with the emergency coordinator or by providing operation and maintenance service.

"(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANIZATIONS.—Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

"(1) any funds appropriated pursuant to this section; and

"(2) any funds appropriated for the purpose of providing water supply, sewage disposal, or solid waste facilities;

on an equal basis with programs that are administered directly by the Service.

"(h) REPORT.—

"(1) IN GENERAL.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report which sets forth—

"(A) the current Indian sanitation facility priority system of the Service;

"(B) the methodology for determining sanitation deficiencies;

"(C) the level of initial and final sanitation deficiency for each type sanitation facility for each project of each Indian tribe or community; and

"(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian tribes and communities to a level I sanitation deficiency as described in paragraph (4)(A).

"(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall

consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any funding agreements entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe and in developing the criteria on which the needs will be evaluated through a process of negotiated rulemaking.

"(3) METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

"(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual or community sanitation facility serving Indian homes are as follows:

"(A) A level I deficiency is a sanitation facility serving and individual or community—

"(i) which complies with all applicable water supply, pollution control and solid waste disposal laws; and

"(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs.

"(B) A level II deficiency is a sanitation facility serving and individual or community—

"(i) which substantially or recently complied with all applicable water supply, pollution control and solid waste laws, in which the deficiencies relate to small or minor capital improvements needed to bring the facility back into compliance;

"(ii) in which the deficiencies relate to capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

"(iii) in which the deficiencies relate to the lack of equipment or training by an Indian Tribe or community to properly operate and maintain the sanitation facilities.

"(C) A level III deficiency is an individual or community facility with water or sewer service in the home, piped services or a haul system with holding tanks and interior plumbing, or where major significant interruptions to water

supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies. There is no access to or no approved or permitted solid waste facility available.

"(D) A level IV deficiency is an individual or community facility where there are no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure or where only a washeteria or central facility exists.

"(E) A level V deficiency is the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater disposal.

"(i) DEFINITIONS.—In this section:

"(1) FACILITY.—The terms 'facility' or 'facilities' shall have the same meaning as the terms 'system' or 'systems' unless the context requires otherwise.

"(2) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

"(1) ownership and control by Indians;

"(2) equipment;

"(3) bookkeeping and accounting procedures;

"(4) substantive knowledge of the project or function to be contracted for;

"(5) adequately trained personnel; or

"(6) other necessary components of contract performance.

"(b) EXEMPTION FROM DAVIS-BACON.—For the purpose of implementing the provisions of this title, construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are exempt from the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act). For all health facilities, staff quarters and sanitation facilities, construction and renovation subcontractors shall be paid wages at rates that are not less than the prevailing wage rates for similar construction in the locality involved, as determined by the Indian tribe, Tribes, or tribal organizations served by such facilities.

"SEC. 304. SOBOBA SANITATION FACILITIES.

"Nothing in the Act of December 17, 1970 (84 Stat. 1465) shall be construed to preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat 674), as amended by the Act of July 31, 1959 (73 Stat. 267).

"SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

"(a) PERMISSIBILITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to accept any major expansion, renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act, including—

"(A) any plans or designs for such expansion, renovation or modernization; and

"(B) any expansion, renovation or modernization for which funds appropriated under any Federal law were lawfully expended;

but only if the requirements of subsection (b) are met.

"(2) PRIORITY LIST.—The Secretary shall maintain a separate priority list to address the need for increased operating expenses, personnel or equipment for such facilities described in paragraph (1). The methodology for establishing priorities shall be developed by negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian tribes and tribal organizations.

"(3) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, the priority list maintained pursuant to paragraph (2).

"(b) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation or modernization if—

"(1) the tribe or tribal organization—

"(A) provides notice to the Secretary of its intent to expand, renovate or modernize; and

"(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel or equipment; and

"(2) the expansion renovation or modernization—

"(A) is approved by the appropriate area director of the Service for Federal facilities; and

"(B) is administered by the Indian tribe or tribal organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

"(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FACILITY TO BE USED AS A SERVICE FACILITY.—If any Service facility which has been expanded, renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation or modernization.

"SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

"(a) AVAILABILITY OF FUNDING.—

"(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to tribes and tribal organizations for the construction, expansion, or modernization of facili-

ties for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided for in subsections (b)(2) and (c)(1)(C)). Funding under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

"(2) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian tribe or tribal organization) pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—Funds provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

"(A) located apart from a hospital;

"(B) not funded under section 301 or section 307; and

"(C) which, upon completion of such construction, expansion, or modernization will—

"(i) have a total capacity appropriate to its projected service population;

"(ii) provide annually not less than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B); and

"(iii) provide ambulatory care in a service area (specified in the funding agreement entered into under the Indian Self-Determination and Education Assistance Act) with a population of not less than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B).

"(2) LIMITATION.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion or modernization project that benefits the service population described in clauses (ii) and (iii) of paragraph (1)(C). The requirements of such clauses (ii) and (iii) shall

not apply to a tribe or tribal organization applying for funding under this section whose principal office for health care administration is located on an island or where such office is not located on a road system providing direct access to an inpatient hospital where care is available to the service population.

"(c) APPLICATION AND PRIORITY.—

"(1) APPLICATION.—No funding may be made available under this section unless an application for such funding has been submitted to and approved by the Secretary. An application or proposal for funding under this section shall be submitted in accordance with applicable regulations and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section—

"(A) adequate financial support will be available for the provision of services at such facility;

"(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

"(C) such facility will, as feasible without diminishing the quality or quantity of services

provided to eligible Indians, serve noneligible persons on a cost basis.

"(2) PRIORITY.—In awarding funds under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

"A) a need for increased ambulatory care services; and

"(B) insufficient capacity to deliver such services.

"(d) FAILURE TO USE FACILITY AS HEALTH FACILITY.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian tribe or tribal organization.

"(e) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Edu-

cation Assistance Act or for reallocation or redesign thereunder.

"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

"(a) HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, may enter into funding agreements with, or make grants or loan guarantees to, Indian tribes or tribal organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through health facilities, including hospice, traditional Indian health and child care facilities, to Indians.

"(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

"(1) waive any leasing prohibition;

"(2) permit carryover of funds appropriated for the provision of health care services;

"(3) permit the use of other available funds;

"(4) permit the use of funds or property donated from any source for project purposes;

"(5) provide for the reversion of donated real or personal property to the donor; and

"(6) permit the use of Service funds to match other funds, including Federal funds.

"(c) CRITERIA.—

"(1) IN GENERAL.—The Secretary shall develop and publish regulations through rulemaking under section 802 for the review and approval of applications submitted under this section. The Secretary may enter into a contract, funding agreement or award a grant under this section for projects which meet the following criteria:

"(A) There is a need for a new facility or program or the reorientation of an existing facility or program.

"(B) A significant number of Indians, including those with low health status, will be served by the project.

"(C) The project has the potential to address the health needs of Indians in an innovative manner.

"(D) The project has the potential to deliver services in an efficient and effective manner.

"(E) The project is economically viable.

"(F) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

"(G) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

"(2) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such applications using the criteria developed pursuant to paragraph (1).

"(3) PRIORITY.—The Secretary shall give priority to applications for demonstration projects under this section in each of the following service units to the extent that such applications are filed in a timely manner and otherwise meet the criteria specified in paragraph (1):

"(A) Cass Lake, Minnesota.

"(B) Clinton, Oklahoma.

"(C) Harlem, Montana.

"(D) Mescalero, New Mexico.

"(E) Owyhee, Nevada.

"(F) Parker, Arizona.

"(G) Schurz, Nevada.

"(H) Winnebago, Nebraska.

"(I) Ft. Yuma, California

"(d) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

"(e) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health care practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

"(f) EQUITABLE TREATMENT.—For purposes of subsection (c)(1)(A), the Secretary shall, in evaluating facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

"(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation and expansion needs of Service and

non-Service facilities which are the subject of a funding agreement for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

"SEC. 308. LAND TRANSFER.

"(a) GENERAL AUTHORITY FOR TRANSFERS.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

"(b) CHEMAWA INDIAN SCHOOL.—The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.

"SEC. 309. LEASES.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized, in carrying out

the purposes of this Act, to enter into leases with Indian tribes and tribal organizations for periods not in excess of 20 years. Property leased by the Secretary from an Indian tribe or tribal organization may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe or tribal organization.

"(b) FACILITIES FOR THE ADMINISTRATION AND DELIVERY OF HEALTH SERVICES.—The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

"(1) title to;

"(2) a leasehold interest in; or

"(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and

maintenance expenses, and other expenses determined by regulation to be allowable pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

"SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAYMENT.

"(a) HEALTH CARE FACILITIES LOAN FUND.—There is established in the Treasury of the United States a fund to be known as the 'Health Care Facilities Loan Fund' (referred to in this Act as the 'HCFLF') to provide to Indian Tribes and tribal organizations direct loans, or guarantees for loans, for the construction of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities such as behavioral health and elder care facilities).

"(b) STANDARDS AND PROCEDURES.—The Secretary may promulgate regulations, developed through rulemaking as provided for in section 802, to establish standards and procedures for governing loans and loan guarantees under this section, subject to the following conditions:

"(1) The principal amount of a loan or loan guarantee may cover up to 100 percent of eligible costs, including costs for the planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements,

medical equipment and furnishings, other facility related costs and capital purchase (but excluding staffing).

"(2) The cumulative total of the principal of direct loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

"(3) In the discretion of the Secretary, the program under this section may be administered by the Service or the Health Resources and Services Administration (which shall be specified by regulation).

"(4) The Secretary may make or guarantee a loan with a term of the useful estimated life of the facility, or 25 years, whichever is less.

"(5) The Secretary may allocate up to 100 percent of the funds available for loans or loan guarantees in any year for the purpose of planning and applying for a loan or loan guarantee.

"(6) The Secretary may accept an assignment of the revenue of an Indian tribe or tribal organization as security for any direct loan or loan guarantee under this section.

"(7) In the planning and design of health facilities under this section, users eligible under section

807(b) may be included in any projection of patient population.

"(8) The Secretary shall not collect loan application, processing or other similar fees from Indian tribes or tribal organizations applying for direct loans or loan guarantees under this section.

"(9) Service funds authorized under loans or loan guarantees under this section may be used in matching other Federal funds.

"(c) FUNDING.—

"(1) IN GENERAL.—The HCFLF shall consist of—

"(A) such sums as may be initially appropriated to the HCFLF and as may be subsequently appropriated under paragraph (2);

"(B) such amounts as may be collected from borrowers; and

"(C) all interest earned on amounts in the HCFLF.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the

amount collected by the HCFLF during the preceding fiscal year, and all accrued interest on such amounts.

"(3) AVAILABILITY OF FUNDS.—Amounts appropriated, collected or earned relative to the HCFLF shall remain available until expended.

"(d) FUNDING AGREEMENTS.—Amounts in the HCFLF and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service, to make loans under this section to an Indian tribe or tribal organization pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

"(e) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the HCFLF as such Secretary determines are not required to meet current withdrawals from the HCFLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the fund may be sold by the Secretary of the Treasury at the market price.

"(f) GRANTS.—The Secretary is authorized to establish a program to provide grants to Indian tribes and trib-

al organizations for the purpose of repaying all or part of any loan obtained by an Indian tribe or tribal organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

"SEC. 311. TRIBAL LEASING.

"Indian Tribes and tribal organizations providing health care services pursuant to a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

"SEC. 312. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

"(a) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian tribes and tribal organizations to establish joint venture demonstration projects under which an Indian tribe or tribal organization shall expend tribal, private, or other available funds, for the acquisi-

tion or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility.

"(2) USE OF RESOURCES.—A tribe or tribal organization may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

"(3) ELIGIBILITY OF CERTAIN ENTITIES.—A tribe that has begun and substantially completed the process of acquisition or construction of a health facility shall be eligible to establish a joint venture project with the Service using such health facility.

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall enter into an arrangement under subsection (a)(1) with an Indian tribe or tribal organization only if—

"(A) the Secretary first determines that the Indian tribe or tribal organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in subsection (a)(1); and

"(B) the Indian tribe or tribal organization meets the needs criteria that shall be developed through the negotiated rulemaking process provided for under section 802.

"(2) CONTINUED OPERATION OF FACILITY.—The Secretary shall negotiate an agreement with the Indian tribe or tribal organization regarding the continued operation of a facility under this section at the end of the initial 10 year no-cost lease period.

"(3) BREACH OR TERMINATION OF AGREEMENT.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe or tribal organization, or paid to a third party on the tribe's or tribal organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence shall not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

"(d) RECOVERY FOR NON-USE.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility should at any time within 10 years the Service ceases to use the facility or otherwise breaches the agreement.

"(e) DEFINITION.—In this section, the terms 'health facility' or 'health facilities' include staff quarters needed to provide housing for the staff of the tribal health program.

"SEC. 313. LOCATION OF FACILITIES.

"(a) PRIORITY.—The Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

"(b) DEFINITION.—In this section, the term 'Indian lands' means—

"(1) all lands within the exterior boundaries of any Indian reservation;

"(2) any lands title to which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power; and

"(3) all lands in Alaska owned by any Alaska Native village, or any village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

"SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

"(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

"(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

"(1) IN GENERAL.—The Secretary may expend maintenance and improvement funds to support the maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian tribe or tribal organization.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'supportable space allocation' shall be defined through the negotiated rulemaking process provided for under section 802.

"(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

"(1) IN GENERAL.—In addition to using maintenance and improvement funds for the maintenance of facilities under subsection (b)(1), an Indian tribe or tribal organization may use such funds for the construction of a replacement facility if the costs of the renovation of such facility would exceed a maximum renovation cost threshold.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'maximum renovation cost threshold' shall be defined through the negotiated rulemaking process provided for under section 802.

"SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED QUARTERS.

"(a) ESTABLISHMENT OF RENTAL RATES.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the Federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

"(2) OBJECTIVES.—In establishing rental rates under paragraph (1), an Indian tribe or tribal organization shall attempt to achieve the following objectives:

"(A) The rental rates should be based on the reasonable value of the quarters to the occupants thereof.

"(B) The rental rates should generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and, subject to the discretion of the Indian tribe or tribal organization, to supply reserve funds for capital repairs and replacement of the quarters.

"(3) ELIGIBILITY FOR QUARTERS IMPROVEMENT AND REPAIR.—Any quarters whose rental

rates are established by an Indian tribe or tribal organization under this subsection shall continue to be eligible for quarters improvement and repair funds to the same extent as other Federally-owned quarters that are used to house personnel in Service-supported programs.

"(4) NOTICE OF CHANGE IN RATES.—An Indian tribe or tribal organization that exercises the authority provided under this subsection shall provide occupants with not less than 60 days notice of any change in rental rates.

"(b) COLLECTION OF RENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), an Indian tribe or a tribal organization that operates Federally-owned quarters pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

"(A) The Indian tribe or tribal organization shall notify the Secretary and the Federal employees involved of its election to exercise its authority to collect rents directly from such Federal employees.

"(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

"(C) Such rent payments shall be retained by the Indian tribe or tribal organization and shall not be made payable to or otherwise be deposited with the United States.

"(D) Such rent payments shall be deposited into a separate account which shall be used by the Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

"(2) RETROCESSION.—If an Indian tribe or tribal organization which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying Federally-owned quarters, such retrocession shall become effective on the earlier of—

"(A) the first day of the month that begins not less than 180 days after the Indian tribe or tribal organization notifies the Secretary of its desire to retrocede; or

"(B) such other date as may be mutually agreed upon by the Secretary and the Indian tribe or tribal organization.

"(c) RATES.—To the extent that an Indian tribe or tribal organization, pursuant to authority granted in subsection (a), establishes rental rates for Federally-owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.–

"SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

"(a) IN GENERAL.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to the authorization contained in section 318, except that Indian tribes and tribal organizations shall be exempt from such requirements.

"(b) FALSE OR MISLEADING LABELING.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made

in America' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to the authorization contained in section 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(c) DEFINITION.—In this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

"SEC. 317. OTHER FUNDING FOR FACILITIES.

"Notwithstanding any other provision of law—

"(1) the Secretary may accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design and construct health care facilities for Indians and to place such funds into funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary

and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

"(2) the Secretary may enter into interagency agreements with other Federal or State agencies and other entities and to accept funds from such Federal or State agencies or other entities to provide for the planning, design and construction of health care facilities to be administered by the Service or by Indian tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act in order to carry out the purposes of this Act, together with the purposes for which such funds are appropriated to such other Federal or State agency or for which the funds were otherwise provided;

"(3) any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency; and

"(4) the Secretary, acting through the Service, shall establish standards under regulations developed

through rulemaking under section 802, for the planning, design and construction of health care facilities serving Indians under this Act.

"SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE IV—ACCESS TO HEALTH SERVICES

"SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE PROGRAM.

"(a) IN GENERAL.—Any payments received by the Service, by an Indian tribe or tribal organization pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization pursuant to title V of this Act for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care and services to Indians.

"(b) EQUAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act in preference to an Indian beneficiary without such coverage.

"(c) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for benefits under title XVIII of the Social Security Act.

"SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM.

"(a) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such title. Any payments which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes. In making payments from such fund, the Secretary shall ensure that each service unit of the Service receives 100 percent of the amounts to which

the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for medical assistance under title XIX of the Social Security Act.

"(b) PAYMENTS DISREGARDED FOR APPROPRIATIONS.—Any payments received under section 1911 of the Social Security Act for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

"(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405.

"SEC. 403. REPORT.

"(a) INCLUSION IN ANNUAL REPORT.—The Secretary shall submit to the President, for inclusion in the

report required to be transmitted to the Congress under section 801, an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements under titles XVIII and XIX of the Social Security Act.

"(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian tribe or tribal organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an urban Indian organization receives funding from the Service under Title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian tribe or tribal organization, or urban Indian organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

"SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and tribal organizations to assist such organizations in establishing and administering programs on or near Federal In-

dian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

"(1) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(2) pay premiums for health insurance coverage; and

"(3) apply for medical assistance provided pursuant to titles XIX and XXI of the Social Security Act.

"(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

"(1) determine the population of Indians to be served that are or could be recipients of benefits or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

"(2) assist individual Indians in becoming familiar with and utilizing such benefits and assistance;

"(3) provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits and assistance;

"(4) develop and implement—

"(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for health insurance coverage of needy individuals; and

"(B) methods of improving the participation of Indians in receiving the benefits and assistance provided under titles XVIII, XIX, and XXI of the Social Security Act.

"(c) AGREEMENTS FOR RECEIPT AND PROCESSING OF APPLICATIONS.—The Secretary may enter into an agreement with an Indian tribe or tribal organization, or an urban Indian organization, which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act and benefits under title XVIII of such Act by a Service facility or a health care program administered by such Indian tribe or tribal organization, or urban Indian organization, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act or a grant or contract entered into with an urban Indian organization under title

V of this Act. Notwithstanding any other provision of law, such agreements shall provide for reimbursement of the cost of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may be included in an encounter rate or be made on a fee-for-service basis as appropriate for the provider. When necessary to carry out the terms of this section, the Secretary, acting through the Health Care Financing Administration or the Service, may enter into agreements with a State (or political subdivision thereof) to facilitate cooperation between the State and the Service, an Indian tribe or tribal organization, and an urban Indian organization.

"(d) GRANTS.—

"(1) IN GENERAL.—The Secretary shall make grants or enter into contracts with urban Indian organizations to assist such organizations in establishing and administering programs to assist individual urban Indians to—

"(A) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(B) pay premiums on behalf of such individuals for coverage under title XVIII of such Act; and

"(C) apply for medical assistance provided under title XIX of such Act and for child health assistance under title XXI of such Act.

"(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or entered into under paragraph (1) requirements that are—

"(A) consistent with the conditions imposed by the Secretary under subsection (b);

"(B) appropriate to urban Indian organizations and urban Indians; and

"(C) necessary to carry out the purposes of this section.

"SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

"(a) DIRECT BILLING.—

"(1) IN GENERAL.—An Indian tribe or tribal organization may directly bill for, and receive payment for, health care services provided by such tribe or organization for which payment is made under title XVIII of the Social Security Act, under a State plan for medical assistance approved under title XIX of such Act, under a State child health plan approved under title XXI of such Act, or from any other third party payor.

"(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act and section 2101(c) of such Act shall apply for purposes of reimbursement under the medicaid or State children's health insurance program for health care services directly billed under the program established under this section.

"(b) DIRECT REIMBURSEMENT.—

"(1) USE OF FUNDS.—Each Indian tribe or tribal organization exercising the option described in subsection (a) of this section shall be reimbursed directly under the medicare, medicaid, and State children's health insurance programs for services furnished, without regard to the provisions of sections 1880(c) of the Social Security Act and section 402(a) of this Act, but all funds so reimbursed shall first be used by the health program for the purpose of making any improvements in the facility or health programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such health services under the medicare, medicaid, or State children's health insurance program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements

shall be used to provide additional health services, improvements in its health care facilities, or otherwise to achieve the health objectives provided for under section 3 of this Act.

"(2) AUDITS.—The amounts paid to the health programs exercising the option described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare, medicaid, and State children's health insurance programs.

"(3) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 401(c) or section 402(a), no payment may be made out of the special fund described in section 401(c) or 402(a), for the benefit of any health program exercising the option described in subsection (a) of this section during the period of such participation.

"(c) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section,

including any agreements with States that may be necessary to provide for direct billing under the medicaid or State children's health insurance program.

"(d) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

"(e) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the in-

jury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

"(a) RIGHT OF RECOVERY.—Except as provided in subsection (g), the United States, an Indian tribe or tribal organization shall have the right to recover the reasonable charges billed or expenses incurred by the Secretary or an Indian tribe or tribal organization in providing health services, through the Service or an Indian tribe or tribal organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if—

"(1) such services had been provided by a nongovernmental provider; and

"(2) such individual had been required to pay such charges or expenses and did pay such expenses.

"(b) URBAN INDIAN ORGANIZATIONS.—Except as provided in subsection (g), an urban Indian organization shall have the right to recover the reasonable charges

billed or expenses incurred by the organization in providing health services to any individual to the same extent that such individual, or any other nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if such individual had been required to pay such charges or expenses and did pay such charges or expenses.

"(c) LIMITATIONS ON RECOVERIES FROM STATES.—Subsections (a) and (b) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

"(1) workers' compensation laws; or

"(2) a no-fault automobile accident insurance plan or program.

"(d) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States or an Indian tribe or tribal organization under subsection (a), or an urban Indian organization under subsection (b).

"(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery pro-

vided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

"(f) METHODS OF ENFORCEMENT.—

"(1) IN GENERAL.—The United States or an Indian tribe or tribal organization may enforce the right of recovery provided under subsection (a), and an urban Indian organization may enforce the right of recovery provided under subsection (b), by—

"(A) intervening or joining in any civil action or proceeding brought—

"(i) by the individual for whom health services were provided by the Secretary, an Indian tribe or tribal organization, or urban Indian organization; or

"(ii) by any representative or heirs of such individual; or

"(B) instituting a civil action.

"(2) NOTICE.—All reasonable efforts shall be made to provide notice of an action instituted in accordance with paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

"(g) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service, may receive and expend such funds for the provision of additional health services.

"(h) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded reasonable attorneys' fees and costs of litigation.

"(i) RIGHT OF ACTION AGAINST INSURERS AND EMPLOYEE BENEFIT PLANS.—

"(1) IN GENERAL.—Where an insurance company or employee benefit plan fails or refuses to pay

the amount due under subsection (a) for services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the United States or an Indian tribe or tribal organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal, State or tribal law.

"(2) URBAN INDIAN ORGANIZATIONS.—Where an insurance company or employee benefit plan fails or refuses to pay the amounts due under subsection (b) for health services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the urban Indian organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal or State law.

"(j) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization, or an urban Indian organization shall have a right of recovery for any otherwise reimbursable claim filed on a current HCFA-

1500 or UB–92 form, or the current NSF electronic format, or their successors. No health plan shall deny payment because a claim has not been submitted in a unique format that differs from such forms.

"SEC. 407. CREDITING OF REIMBURSEMENTS.

"(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87–693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

"(b) NO OFFSET OF FUNDS.—The Service may not offset or limit the amount of funds obligated to any service unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

"SEC. 408. PURCHASING HEALTH CARE COVERAGE.

"An Indian tribe or tribal organization, and an urban Indian organization may utilize funding from the Sec-

retary under this Act to purchase managed care coverage for Service beneficiaries (including insurance to limit the financial risks of managed care entities) from—

"(1) a tribally owned and operated managed care plan;

"(2) a State or locally-authorized or licensed managed care plan; or

"(3) a health insurance provider.

"SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VETERAN'S AFFAIRS, AND OTHER FEDERAL AGENCY HEALTH FACILITIES AND SERVICES SHARING.

"(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

"(1) IN GENERAL.—The Secretary shall examine the feasibility of entering into arrangements or expanding existing arrangements for the sharing of medical facilities and services between the Service and the Veterans' Administration, and other appropriate Federal agencies, including those within the Department, and shall, in accordance with subsection (b), prepare a report on the feasibility of such arrangements.

"(2) SUBMISSION OF REPORT.—Not later than September 30, 2000, the Secretary shall submit the report required under paragraph (1) to Congress.

"(3) CONSULTATION REQUIRED.—The Secretary may not finalize any arrangement described in paragraph (1) without first consulting with the affected Indian tribes.

"(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

"(1) the priority access of any Indian to health care services provided through the Service;

"(2) the quality of health care services provided to any Indian through the Service;

"(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

"(4) the quality of health care services provided to any veteran by the Veteran's Administration;

"(5) the eligibility of any Indian to receive health services through the Service; or

"(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration provided, however, the Service or the

Indian tribe or tribal organization shall be reimbursed by the Veterans' Administration where services are provided through the Service or Indian tribes or tribal organizations to beneficiaries eligible for services from the Veterans' Administration, notwithstanding any other provision of law.

"(c) AGREEMENTS FOR PARITY IN SERVICES.—The Service may enter into agreements with other Federal agencies to assist in achieving parity in services for Indians. Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Service.

"SEC. 410. PAYOR OF LAST RESORT.

"The Service, and programs operated by Indian tribes or tribal organizations, or urban Indian organizations shall be the payor of last resort for services provided to individuals eligible for services from the Service and such programs, notwithstanding any Federal, State or local law to the contrary, unless such law explicitly provides otherwise.

"SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH CARE PROGRAMS.

"Notwithstanding any other provision of law, the Service, Indian tribes or tribal organizations, and urban Indian organizations (notwithstanding limitations on who

is eligible to receive services from such entities) shall be entitled to receive payment or reimbursement for services provided by such entities from any Federally funded health care program, unless there is an explicit prohibition on such payments in the applicable authorizing statute.

"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

"(a) IN GENERAL.—Notwithstanding any other provision of law, including the Anti-Deficiency Act, provided the Indian tribes to be served approve, the Service in the Tuba City Service Unit may—

"(1) enter into a demonstration project with the State of Arizona under which the Service would provide certain specified medicaid services to individuals dually eligible for services from the Service and for medical assistance under title XIX of the Social Security Act in return for payment on a capitated basis from the State of Arizona; and

"(2) purchase insurance to limit the financial risks under the project.

"(b) EXTENSION OF PROJECT.—The demonstration project authorized under subsection (a) may be extended to other service units in Arizona, subject to the approval of the Indian tribes to be served in such service units, the Service, and the State of Arizona.

"SEC. 413. ACCESS TO FEDERAL INSURANCE.

"Notwithstanding the provisions of title 5, United States Code, Executive Order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.

"SEC. 414. CONSULTATION AND RULEMAKING.

"(a) CONSULTATION.—Prior to the adoption of any policy or regulation by the Health Care Financing Administration, the Secretary shall require the Administrator of that Administration to—

"(1) identify the impact such policy or regulation may have on the Service, Indian tribes or tribal organizations, and urban Indian organizations;

"(2) provide to the Service, Indian tribes or tribal organizations, and urban Indian organizations the information described in paragraph (1);

"(3) engage in consultation, consistent with the requirements of Executive Order 13084 of May 14, 1998, with the Service, Indian tribes or tribal organizations, and urban Indian organizations prior to enacting any such policy or regulation.

"(b) RULEMAKING.—The Administrator of the Health Care Financing Administration shall participate in the negotiated rulemaking provided for under title VIII with regard to any regulations necessary to implement the provisions of this title that relate to the Social Security Act.

"SEC. 415. LIMITATIONS ON CHARGES.

"No provider of health services that is eligible to receive payments or reimbursements under titles XVIII, XIX, or XXI of the Social Security Act or from any Federally funded (whether in whole or part) health care program may seek to recover payment for services—

"(1) that are covered under and furnished to an individual eligible for the contract health services program operated by the Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an

urban Indian organization, in an amount in excess of the lowest amount paid by any other payor for comparable services; or

"(2) for examinations or other diagnostic procedures that are not medically necessary if such procedures have already been performed by the referring Indian health program and reported to the provider.

"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHORITY.

"Notwithstanding any other provision of law, the Secretary may not waive the application of section 1902(a)(13)(D) of the Social Security Act to any State plan under title XIX of the Social Security Act.

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

"Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

"(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

"(1) any Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act;

"(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

"(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2000); or

"(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of this Act (as so in effect), or other applicable law, to

pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization; provided the exchange arises from or relates to such health programs.

"(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES AND PREMIUMS.

"(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an In-

dian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

"(b) EXEMPTION FROM PREMIUMS.—

"(1) MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for medical assistance under title XIX of the Social Security Act or child health assistance under title XXI of such Act may be charged a premium as a condition of receiving such assistance under title XIX of XXI of such Act.

"(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security

Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian Tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

"For the purpose of determining the eligibility under section 1902(a)(10)(A)(ii)(IV) of the Social Security Act of an Indian for medical assistance under a State plan under title XIX of such Act, the cost of providing services to an Indian in a health program of the Service, an Indian Tribe or tribal organization, or an urban Indian organization shall be deemed to have been an expenditure for health care by the Indian.

"SEC. 421. ESTATE RECOVERY PROVISIONS.

"Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of

the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

"(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

"(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of Federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

"(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

"(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

"SEC. 422. MEDICAL CHILD SUPPORT.

"Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization.

For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian Tribe or tribal organization or an urban Indian organization and another health provider.

"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

"(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian Tribe or tribal organization or an urban Indian organization shall have a right of recovery under section 408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian Tribe or tribal organization or an urban Indian organization.

"(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement

may not be made a prerequisite for such payments to be made.

"(c) PARITY.—Payments due under subsection (a) from a managed care entity may not be paid at a rate that is less than the rate paid to a 'preferred provider' by the entity or, in the event there is no such rate, the usual and customary fee for equivalent services.

"(d) NO CLAIM REQUIREMENT.—A managed care entity may not deny payment under subsection (a) because an enrollee with the entity has not submitted a claim.

"(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

"(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered

by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

"(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under any managed care entity participating in a State plan under title XIX or XXI of the Social Security Act unless the Indian had the option of enrolling in a managed care plan or health program administered by the Service, an Indian tribe or tribal organization, or an urban Indian organization.

"(h) INDIAN MANAGED CARE PLANS.—Notwithstanding any other provision of law, any State entering into agreements with one or more managed care organizations to provide services under title XIX or XXI of the Social Security Act shall enter into such an agreement with the Service, an Indian tribe or tribal organization or an urban Indian organization under which such an entity may provide services to Indians who may be eligible or required to enroll with a managed care organization

through enrollment in an Indian managed care organization that provides services similar to those offered by other managed care organizations in the State. The Secretary and the State are hereby authorized to waive requirements regarding discrimination, capitalization, and other matters that might otherwise prevent an Indian managed care organization or health program from meeting Federal or State standards applicable to such organizations, provided such Indian managed care organization or health program offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

"(i) ADVERTISING.—A managed care organization entering into a contract to provide services to Indians on or near an Indian reservation shall provide a certificate of coverage or similar type of document that is written in the Indian language of the majority of the Indian population residing on such reservation.

"SEC. 424. NAVAJO NATION MEDICAID AGENCY.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary may treat the Navajo Nation as a State under title XIX of the Social Security Act for purposes of providing medical assistance to Indians living within the boundaries of the Navajo Nation.

"(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and

pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

"(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

"(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such Nation, include Western and traditional Navajo healing services) within the Navajo Nation. Such assistance may include providing funds for demonstration projects conducted with such Nation.

"(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per cent with respect to amounts the Navajo Nation Medicaid agency expends for medical assistance and related administrative costs.

"(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of Title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

"(g) SCHIP.—At the option of the Navajo Nation, the Secretary may treat the Navajo Nation as a State for purposes of title XXI of the Social Security Act under terms equivalent to those described in the preceding subsections of this section.

"SEC. 425. INDIAN ADVISORY COMMITTEES.

"(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall

include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

"(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

"SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title.".

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"SEC. 501. PURPOSE.

"The purpose of this title is to establish programs in urban centers to make health services more accessible and available to urban Indians.

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

"Under the authority of the Act of November 2, 1921 (25 U.S.C. 13)(commonly known as the Snyder Act), the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within urban centers, of programs which meet the requirements set forth in this title. The Secretary, through the Service, subject to section 506, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

"(a) AUTHORITY.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

"(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

"(2) estimate the current health status of urban Indians residing in such urban center or centers;

"(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

"(4) provide basic health education, including health promotion and disease prevention education, to urban Indians;

"(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

"(6) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

"(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under

this section. Such criteria shall, among other factors, include—

"(1) the extent of unmet health care needs of urban Indians in the urban center or centers involved;

"(2) the size of the urban Indian population in the urban center or centers involved;

"(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

"(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

"(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center or centers; and

"(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

"(c) HEALTH PROMOTION AND DISEASE PREVENTION.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a).

"(d) IMMUNIZATION SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(3) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

"(e) MENTAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) to provide outreach, educational, and referral services to urban Indians regarding the availability of direct behavioral health services, to educate urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to urban Indians;

"(C) to provide outpatient behavioral health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support

groups, family treatment, and other treatment; and

"(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

"(f) CHILD ABUSE.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

"(C) to provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

"(4) CONSIDERATIONS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

"(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child

Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

"(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

"(C) the assessment required under paragraph (2).

"(g) MULTIPLE URBAN CENTERS.—The Secretary, acting through the Service, may enter into a contract with, or make grants to, an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to urban Indians in more than one urban center.

"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

"(a) AUTHORITY.—

"(1) IN GENERAL.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503.

"(2) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary has entered into a contract with, or made a grant to, under this section.

"(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake to—

"(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

"(B) with respect to urban Indians in the urban center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

"(2) the urban Indian organization complete performance of the contract, or carry out the re-

quirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

"(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

"(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title and compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) COMPLIANCE WITH TERMS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian organization which has entered into a contract or received a grant under section 503 with the terms of such contract of grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

"(1) conduct, through the Service, an annual onsite evaluation of the organization; or

"(2) accept, in lieu of an onsite evaluation, evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the medicare program under Title XVIII of the Social Security Act.

"(c) NONCOMPLIANCE.—

"(1) IN GENERAL.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

"(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with

such organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract or grant is not renewed under this section.

"(d) DETERMINATION OF RENEWAL.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

"(a) APPLICATION OF FEDERAL LAW.—Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

"(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

"(1) be made in their entirety by the Secretary to the urban Indian organization by not later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

"(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the expenditure of such funds.

"(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

"(d) FAIR AND UNIFORM PROVISION OF SERVICES.—Contracts with, or grants to, urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

"(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indians, as defined in section 4(f), shall be eligible for health care or referral services provided pursuant to this title.

"SEC. 507. REPORTS AND RECORDS.

"(a) REPORT.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into, or a grant received, pursuant to this title, such organization shall submit to the Secretary, on a basis no more frequent than every 6 months, a report including—

"(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract or grant;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary,

after consultations consistent with section 514, with urban Indian organizations.

"(b) AUDITS.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(c) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

"(1) a certified public accountant; or

"(2) a certified public accounting firm qualified to conduct Federal compliance audits.

"SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

"The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

"SEC. 509. FACILITIES.

"(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

"(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

"(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

"(2) The total amount of the principal of loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriations Acts.

"(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility, or 25 years.

"(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the

revenue of the organization as security for a loan or loan guarantee under this subsection.

"(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

"(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

"(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

"(A) such amounts as may be appropriated to the URLF;

"(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

"(C) interest earned on amounts in the URLF under paragraph (3).

"(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the

requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

"(3) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet current withdrawals from the URLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

"There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

"(1) carrying out the provisions of this title;

"(2) providing central oversight of the programs and services authorized under this title; and

"(3) providing technical assistance to urban Indian organizations.

"SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES.

"(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom the Secretary has entered into a contract under this title or under section 201.

"(b) GOALS OF GRANT.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the—

"(1) size of the urban Indian population;

"(2) capability of the organization to adequately perform the activities required under the grant;

"(3) satisfactory performance standards for the organization in meeting the goals set forth in such grant, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and

"(4) identification of need for services.

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

"(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

"(a) OKLAHOMA CITY CLINIC.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Oklahoma City Clinic demonstration project shall be treated as a service unit in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.

"(2) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and con-

clusions derived from the demonstration project specified in paragraph (1).

"(b) TULSA CLINIC.—Notwithstanding any other provision of law, the Tulsa Clinic demonstration project shall become a permanent program within the Service's direct care program and continue to be treated as a service unit in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

"(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2001, with urban Indian organizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section to as 'NIAAA') and transferred to the Service.

"(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such

other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

"(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

"(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

"SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

"(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension

and which emphasizes trust, respect, and shared responsibility.

"SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

"For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian orga-

nization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

"(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting.

"(b) STATES.—A State described in this subsection is a State in which—

"(1) there reside urban Indian youth with a need for alcohol and substance abuse treatment services in a residential setting; and

"(2) there is a significant shortage of culturally competent residential treatment services for urban Indian youth.

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

"(a) IN GENERAL.—The Secretary shall permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

"(b) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the

General Services Administration for purposes of carrying out the contract or grant.

"(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

"(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian tribe or tribal organization, the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization if the Secretary receives the request from the Indian tribe or tribal organization before the date on which the Secretary transfers title to the property or, if earlier, the date on which the Secretary transfers the property physically, to the urban Indian organization.

"(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, in-

cluding lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

"(a) AUTHORITY.—The Secretary may make grants to those urban Indian organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention, treatment, and control of the complications resulting from, diabetes among urban Indians.

"(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed upon between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

"(1) the size and location of the urban Indian population to be served;

"(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

"(3) performance standards for the urban Indian organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

"(4) the capability of the urban Indian organization to adequately perform the activities required under the grant; and

"(5) the willingness of the urban Indian organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the area office of the Service in which the organization is located.

"(d) APPLICATION OF CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

"SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

"The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health

service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

"SEC. 520. REGULATIONS.

"(a) EFFECT OF TITLE.—This title shall be effective on the date of enactment of this Act regardless of whether the Secretary has promulgated regulations implementing this title.

"(b) PROMULGATION.—

"(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

"(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270 days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

"(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursu-

ant to section 565 of title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

"(d) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of this Act.

"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

"(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

"(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

"(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

"(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for,

and provision and utilization of, health services for Indians;

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

"(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

"(4) all scholarship and loan functions carried out under title I.

"(d) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

"(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, shall establish an automated management information system for the Service.

"(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

"(A) a financial management system;

"(B) a patient care information system;

"(C) a privacy component that protects the privacy of patient information;

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

"(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

"(2) meet the management information needs of the Service.

"(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable

access to the medical or health records of such patient which are held by, or on behalf of, the Service.

"(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

"(a) PURPOSES.—It is the purpose of this section to—

"(1) authorize and direct the Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration

among alcohol and substance abuse, social services, and mental health programs;

"(2) provide information, direction and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement and judicial services;

"(3) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

"(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

"(5) ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access; and

"(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(b) BEHAVIORAL HEALTH PLANNING.—

"(1) AREA-WIDE PLANS.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for Indian Behavioral Health Services. The plans shall, to the extent feasible, include—

"(A) an assessment of the scope of the problem of alcohol or other substance abuse, mental illness, dysfunctional and self-destructive behavior, including suicide, child abuse and family violence, among Indians, including—

"(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; and

"(ii) an estimate of the financial and human cost attributable to such illness or behavior;

"(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

"(C) an estimate of the additional funding needed by the Service, Indian tribes, tribal organizations and urban Indian organizations to meet their responsibilities under the plans.

"(2) NATIONAL CLEARINGHOUSE.—The Secretary shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such plans and outcomes by any Indian tribe, tribal organization, urban Indian organization or the Service.

"(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be utilized and adopted locally.

"(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

"(1) a comprehensive continuum of behavioral health care that provides for—

"(A) community based prevention, intervention, outpatient and behavioral health aftercare;

"(B) detoxification (social and medical);

"(C) acute hospitalization;

"(D) intensive outpatient or day treatment;

"(E) residential treatment;

"(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

"(G) emergency shelter;

"(H) intensive case management; and

"(I) traditional health care practices; and

"(2) behavioral health services for particular populations, including—

"(A) for persons from birth through age 17, child behavioral health services, that include—

"(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

"(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (multiple diagnosis);

"(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

"(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

"(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

"(vii) co-morbidity services;

"(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

"(i) early intervention, treatment and aftercare services;

"(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

"(iv) healthy choices and life style services (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

"(v) female specific treatment services for—

"(I) women at risk of giving birth to a child with a fetal alcohol disorder;

"(II) substance abuse requiring gender specific services;

"(III) sexual assault and domestic violence; and

"(IV) healthy choices and life style (parenting, partners, obesity,

suicide and other related behavioral risk); and

"(vi) male specific treatment services for—

"(I) substance abuse requiring gender specific services;

"(II) sexual assault and domestic violence; and

"(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

"(C) family behavioral health services, including—

"(i) early intervention, treatment and aftercare for affected families;

"(ii) treatment for sexual assault and domestic violence; and

"(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

"(D) for persons age 56 years and older, elder behavioral health services including—

"(i) early intervention, treatment and aftercare services that include—

"(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

"(III) healthy choices and life style services (managing conditions related to aging);

"(ii) elder women specific services that include—

"(I) treatment for substance abuse requiring gender specific services and

"(II) treatment for sexual assault, domestic violence and neglect;

"(iii) elder men specific services that include—

"(I) treatment for substance abuse requiring gender specific services; and

"(II) treatment for sexual assault, domestic violence and neglect; and

"(iv) services for dementia regardless of cause.

"(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

"(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

"(2) TECHNICAL ASSISTANCE.—In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe

or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

"(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

"(e) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

"(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conver-

sion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

"SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

"(1) the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

"(2) the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

"(3) the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

"(4)(A) the right of Indians, as citizens of the United States and of the States in which they reside, to have access to mental health services to which all citizens have access;

"(B) the right of Indians to participate in, and receive the benefit of, such services; and

"(C) the actions necessary to protect the exercise of such right;

"(5) the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

"(6) a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

"(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diag-

nosed individuals requiring mental health and substance abuse treatment; and

"(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

"(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412); and

"(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

"(b) SPECIFIC PROVISIONS.—The memorandum of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

"(1) the determination of the scope of the problem of alcohol and substance abuse among Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

"(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

"(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

"(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

"(1) Indian tribes and tribal organizations;

"(2) Indian individuals;

"(3) urban Indian organizations and other Indian organizations;

"(4) behavioral health service providers.

"(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Fed-

eral Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

"SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including traditional health care practices, which shall include—

"(A) prevention, through educational intervention, in Indian communities;

"(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

"(C) community-based rehabilitation and aftercare;

"(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

"(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children.

"(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

"(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

"SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

"(1) provides for the training of Indians as mental health technicians; and

"(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

"(b) TRAINING.—In carrying out subsection (a)(1), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

"(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

"(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section involves the utilization and promotion of the traditional

Indian health care and treatment practices of the Indian tribes to be served.–

"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

"Subject to section 220, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

"(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling psychologist;

"(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

"(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

"(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

"(b) USE OF FUNDS.—Funding provided pursuant to this section may be used to—

"(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

"(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

"(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

"(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

"(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 707. INDIAN YOUTH PROGRAM.

"(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

"(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment

center or treatment network in each area under the jurisdiction of an area office.

"(B) AREA OFFICE IN CALIFORNIA.—For purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

"(2) FUNDING.—For the purpose of staffing and operating centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

"(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) that is agreed upon (by appropriate tribal resolution) by a majority of the tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska;

"(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l));

"(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

"(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treat-

ment Center, a residential youth treatment facility in New Mexico.

"(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youth residing in such State.

"(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes and tribal organizations, may provide intermediate behavioral health services, which may incorporate traditional health care practices, to Indian children and adolescents, including—

"(A) pre-treatment assistance;

"(B) inpatient, outpatient, and after-care services;

"(C) emergency care;

"(D) suicide prevention and crisis intervention; and

"(E) prevention and treatment of mental illness, and dysfunctional and –self-destructive

behavior, including child abuse and family violence.

"(2) USE OF FUNDS.—Funds provided under this subsection may be used—

"(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

"(B) to hire behavioral health professionals;

"(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided; and

"(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

"(E) intensive home and community based services.

"(3) CRITERIA.—The Secretary shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

"(d) FEDERALLY OWNED STRUCTURES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

"(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youth; and

"(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

"(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

"(e) REHABILITATION AND AFTERCARE SERVICES.—

"(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and imple-

ment within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

"(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used

for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

"(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youth residing in Indian communities, on Indian reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youth.

"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION AND STAFFING ASSESSMENT. —

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems.

"(b) TREATMENT OF CALIFORNIA.—For purposes of this section, California shall be considered to be 2 areas of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California

and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

"(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.–

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

"(a) COMMUNITY EDUCATION.—

"(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each service unit or tribal program a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community.

"(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

"(3) TRAINING.—Community-based training (oriented toward local capacity development) under a

program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

"(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders, to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

"(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and

provide community-based training models. Such models shall address—

"(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

"(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 710. BEHAVIORAL HEALTH PROGRAM.

"(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian Tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

"(1) Whether the project will address significant unmet behavioral health needs among Indians.

"(2) Whether the project will serve a significant number of Indians.

"(3) Whether the project has the potential to deliver services in an efficient and effective manner.

"(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

"(5) Whether the project will deliver services in a manner consistent with traditional health care.

"(6) Whether the project is coordinated with, and avoids duplication of, existing services.

"(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

"(a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the pur-

poses of meeting the health status objective specified in section 3(b).

"(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

"(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

"(B) identify and provide behavioral health treatment to high-risk women;

"(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

"(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

"(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

"(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

"(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

"(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

"(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

"(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

"(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

"(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the

special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

"(c) TASK FORCE.—

"(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

"(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

"(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian

Tribes, tribal organizations and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol disorders.

"(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

"(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

"(1) victims of child sexual abuse; and

"(2) perpetrators of child sexual abuse.

"(b) USE OF FUNDS.—Funds provided under this section shall be used to—

"(1) develop and provide community education and prevention programs related to child sexual abuse;

"(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

"(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

"(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

"(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated, and to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

"SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

"(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, tribal organizations and urban Indian organizations or, enter into

contracts with, or make grants to appropriate institutions, for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

"(1) the inter-relationship and inter-dependance of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

"(2) the development of models of prevention techniques.

"(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

"SEC. 714. DEFINITIONS.

"In this title:

"(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis and dissemination of information on health status, health needs and health problems.

"(2) ALCOHOL RELATED NEURODEVELOP-MENTAL DISORDERS.—The term 'alcohol related

neurodevelop-mental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(4) BEHAVIORAL HEALTH AFTERCARE.—

"(A) IN GENERAL.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse

or mental health outpatient or outpatient treatment, to help prevent or treat relapse, including the development of an aftercare plan.

"(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

"(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.–

"(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

"(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be met:

"(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

"(B) Craniofacial abnormalities with at least 2 of the following: microphthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

"(C) Prenatal or postnatal growth delay.

"(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means a history of maternal alcohol consumption during pregnancy having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

"(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.–

"(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse. —

"SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VIII—MISCELLANEOUS

"SEC. 801. REPORTS.

"The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—

"(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population, including specific comparisons of appropriations provided and those required for such parity;

"(2) a report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the allocation of funding pursuant to section 808;

"(3) a report on the use of health services by Indians—

"(A) on a national and area or other relevant geographical basis;

"(B) by gender and age;

"(C) by source of payment and type of service;

"(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

"(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

"(4) a report of contractors concerning health care educational loan repayments under section 110;

"(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

"(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

"(7) a report on infectious diseases as required under section 212;

"(8) a report on environmental and nuclear health hazards as required under section 214;

"(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

"(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

"(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

"(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

"(13) a report providing an accounting of reimbursement funds made available to the Secretary

under titles XVIII and XIX of the Social Security Act as required under section 403(a);

"(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

"(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

"(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

"(17) a report on the evaluation of programs as required under section 513; and

"(18) a report on alcohol and substance abuse as required under section 701(f).

"SEC. 802. REGULATIONS.

"(a) INITIATION OF RULEMAKING PROCEDURES.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act.

"(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

"(b) RULEMAKING COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of Title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian tribes, and tribal organizations, a majority of whom shall be nominated by and be representatives of Indian tribes, tribal organizations, and urban Indian organizations from each service area.

"(c) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

"(d) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

"(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

"SEC. 803. PLAN OF IMPLEMENTATION.

"Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

"SEC. 804. AVAILABILITY OF FUNDS.

"Amounts appropriated under this Act shall remain available until expended.

"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

"Any limitation on the use of funds contained in an Act providing appropriations for the Department for a pe-

riod with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a Federally recognized Indian tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(A) is a member of the Indian community served by a local program of the Service; and

"(B) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of

California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(b) RULE OF CONSTRUCTION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

"(a) INELIGIBLE PERSONS.—

"(1) IN GENERAL.—Any individual who—

"(A) has not attained 19 years of age;

"(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

"(C) is not otherwise eligible for the health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has

been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

"(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

"(b) PROGRAMS AND SERVICES.—

"(1) PROGRAMS.—

"(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other

subsection of this section or under any other provision of law if—

"(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

"(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

"(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

"(II) there is no reasonable alternative health program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

"(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under

such funding agreement is authorized to determine whether health services should be provided under such funding agreement to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

"(2) LIABILITY FOR PAYMENT.—

"(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the

account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

"(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent person.

"(3) SERVICE AREAS.—

"(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing

body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

"(c) PURPOSE FOR PROVIDING SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

"(1) achieve stability in a medical emergency;

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

"(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or

"(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

"(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

"(e) DEFINITION.—In this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

"SEC. 808. REALLOCATION OF BASE RESOURCES.

"(a) REQUIREMENT OF REPORT.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a service unit may be implemented only after the Secretary has submitted to the

President, for inclusion in the report required to be transmitted to the Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

"(b) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

"SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

"The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

"SEC. 810. PROVISION OF SERVICES IN MONTANA.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr. 1987).

"(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

"During the period of the moratorium imposed by Public Law 100–446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

"For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, Chapter 372), an Indian tribe or tribal organization carrying out a funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

"For purposes of section 4 of Public Law 102–585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be deemed to be an executive agency and part of the Service in the and, as such, may act as an ordering agent of the

Service and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

"(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

"(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

"(1) Ten members of Congress, of which—

"(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

"(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

"(C) two members shall be from the Senate and shall be appointed by the majority leader; and

"(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the pro-

vision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

"(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected by the Indian tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

"(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian Tribes.

"(c) TERMS.—

"(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

"(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

"(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

"(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

"(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

"(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian Tribes;

"(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

"(A) to the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian tribes, tribal organizations and urban Indian organizations, and which may include authorizing and funding feasibility studies of various models for providing and funding health services for all Indian beneficiaries including those who live outside of a reservation, temporarily or permanently;

"(B) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provide,d and the

cost, including mechanisms for funding of the health services to be provided;

"(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

"(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

"(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each Federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

"(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

"(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a

recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

"(e) ADMINISTRATIVE PROVISIONS.—

"(1) COMPENSATION AND EXPENSES.—

"(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

"(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), while serving on the business of the Commission (including travel time) shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States

Code, and while so serving away from home and the member's regular place of business, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(2) MEETINGS AND QUORUM.—

"(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

"(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

"(3) DIRECTOR AND STAFF.—

"(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

"(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

"(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

"(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

"(E) FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals

required for the proper functioning of the Commission.

"(f) POWERS.—

"(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, except that at least 6 regional hearings shall be held in different areas of the United States in which large numbers of Indians are present. Such hearings shall be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this paragraph, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established under this section may be counted towards the number of regional hearings required by this paragraph.

"(2) STUDIES BY GAO.—Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

"(3) COST ESTIMATES.—

"(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

"(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

"(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any federal Agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the federal employee.

"(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal Agency shall provide such technical assistance to the

Commission as the Commission determines to be necessary to carry out its duties.

"(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal Agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

"(7) OBTAINING INFORMATION.—The Commission may secure directly from the any Federal Agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

"(8) SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

"(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

"SEC. 815. APPROPRIATIONS; AVAILABILITY.

"Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

"SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.".

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by adding a semicolon at the end;

(2) in subparagraph (S), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.".

SEC. 202. INDIAN HEALTH PROGRAMS.

Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended to read as follows:

"INDIAN HEALTH PROGRAMS

"SEC. 1880. (a) ELIGIBILITY FOR PAYMENTS.—The Indian Health Service (referred to in this section as the 'Service') and an Indian tribe or tribal organization, or

an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization meets the conditions and requirements for such payments which are applicable generally to the service or provider type for which the Service, Indian tribe or tribal organization, or urban Indian organization seeks payment under this title and for services and provider types provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Service, an Indian tribe or tribal organization, or urban Indian organization, does not meet all of the conditions and requirements of this title which are applicable generally to the service or provider type for which payment is sought, but submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compli-

ance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act.

"(d) COMMUNITY HEALTH AIDES.—The Service or an Indian Tribe or tribal organization providing a service otherwise eligible for payment under this section through the use of a community health aide or practitioner certified under the provisions of section 121 of the Indian Health Care Improvement Act shall be paid for such services on the same basis that such services are reimbursed under State plans approved under title XIX.

"(e) TREATMENT OF CERTAIN PROGRAMS.—Notwithstanding any other provision of law, a health program operated by the Service or an Indian tribe or tribal organization, which collaborates with a hospital operated by the Service or an Indian tribe or tribal organization, shall, at the option of the Indian tribe or tribal organization, be paid for services for which it would otherwise be eligible

for under this as if the health program were an outpatient department of the hospital. In situations where the health program is on a separate campus from the hospital, billing as an outpatient department of the hospital shall not subject such a health program to the requirements of section 1867.

"(f) PAYMENT FOR CERTAIN NURSING SERVICES.—The Service or an Indian tribe or tribal organization providing visiting nurse services in a home health agency shortage area shall be paid for such services on the same basis that such services are reimbursed under this title for other primary care providers.

"(g) ALTERNATIVE METHODS OF REIMBURSEMENT.—Notwithstanding any other provision of law, the Secretary may identify and implement alternative methods of reimbursing Indian health programs for services reimbursable under this title that are provided to Indians, so long as such methods—

"(1) allow an Indian tribe or tribal organization or urban Indian organization to opt to receive reimbursement under reimbursement methodologies applicable to other providers of similar services; and

"(2) provide that the amount of reimbursement resulting under any such methodology shall not be less than 100 percent of the reasonable cost of the

service to which the methodology applies under section 1861(v).".

SEC. 203. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

"QUALIFIED INDIAN HEALTH PROGRAM

"SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

"(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by—

"(A) the Indian Health Service;

"(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; and

"(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

"(2) INCLUDED PROGRAMS AND ENTITIES.—Such term may include 1 or more hospital, nursing

home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

"(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

"(c) DETERMINATION OF PAYMENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

"(2) DEFINITION OF FULL COST RECOVERY.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

"(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into ac-

count the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

"(ii) indirect costs which, in the case of a qualified Indian health program—

"(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

"(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

"(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or

deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

"(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

"(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

"(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

"(B) NO SINGLE REPORT REQUIREMENT.—Not all health programs provided or administered by the Indian Health Service, an

Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

"(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report shall be made on a fee-for-service, encounter, or per diem basis.

"(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

"(A) a significant decrease in discharges;

"(B) costs for graduate medical education programs;

"(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

"(D) payment for outlier cases.

"(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

"(A) on the full cost recovery basis provided in paragraphs (1) through (5);

"(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

"(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

"(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian Tribe or tribal organization; or

"(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

"(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

"(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

"(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

"(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

"(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health setting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

"(C) preventive primary health services as described under sections 329, 330, and 340 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

"(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screen-

ing, diagnostic, and treatment services as described in section 1905(r);

"(E) influenza and pneumococcal immunizations;

"(F) other immunizations for prevention of communicable diseases when targeted; and

"(G) the cost of transportation for providers or patients necessary to facilitate access for patients.".

Subtitle B—Medicaid

SEC. 211. PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.

Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended—

(1) in subparagraph (B), by striking "and" at the end;

(2) in subparagraph (C), by adding "and" at the end; and

(3) by adding at the end the following:

"(D)(i) for payment for services described in section 1905(a)(2)(C) under the plan furnished by an Indian tribe or tribal organization or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) of 100 percent of costs which are

reasonable and related to the cost of furnishing such services or based on other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, the same methodology used under section 1833(a)(3), and

"(ii) in the case of such services furnished pursuant to a contract between a Federally-qualified health center and a medicaid managed care organization under section 1903(m), for payment to the Federally-qualified health center at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract.".

SEC. 212. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (65), by striking the period; and

(2) by inserting after (65), the following:

"(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

"(A) the term 'meaningful consultation' is defined through the negotiated rulemaking process provided for under section 802 of the Indian Health Care Improvement Act; and

"(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.".

SEC. 213. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

"Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.".

SEC. 214. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

"INDIAN HEALTH SERVICE PROGRAMS

"SEC. 1911. (a) IN GENERAL.—The Indian Health Service and an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as such Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable generally to the service for which it seeks reimbursement

under this title and for services provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations and urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian

Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking "For purposes" and inserting the following:

"(1) IN GENERAL.—Subject to paragraph (2), for purposes"; and

(2) by adding at the end the following:

"(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).".

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting "an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)" after "Service".

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

"(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

"(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

"(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

"(2) under an agreement entered into under subsection (a) between the entity and the Secretary.".

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101–630 (25 U.S.C. 1653 note) is repealed.

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

○

The CHAIRMAN. We will start with panel 1 which will be Taylor McKenzie, M.D., the vice president of the Navajo Nation; Julia Davis, member, National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. She holds the chair of the Northwest Portland Area Indian Health Board; Yvette Roubideaux, M.D., president, Association of American Indian Physicians; and Barbara Dahlen, the assistant coordinator of the Recruitment and Retention of American Indians into Nursing.

With that, I would welcome you to the committee. Why don't we just go ahead in the order we announced with Dr. McKenzie starting first?

STATEMENT OF TAYLOR McKENZIE, VICE PRESIDENT, NAVAJO NATION, WINDOW ROCK, AZ

The CHAIRMAN. Since we got off to an awful late start since we had a vote, your full written testimony will be included in the record. If you could be concise and abbreviate a little bit, the committee would appreciate that. Dr. McKenzie.

Mr. MCKENZIE. Honorable Chairman Campbell and Honorable Senator Inouye, and members of the Senate Committee on Indian Affairs, my name is Taylor McKenzie, vice president of the Navajo Nation.

I am here today on behalf of the Navajo Nation to testify in support of the Indian Health Care Improvement Act, Public Law 94–437. The legislation I am testifying on today is the result of many regional meetings between tribes, tribal organizations and urban Indian organizations.

These meetings gave rise to the National Public Law 94–437 Steering Committee. I had the honor of serving as chair for titles I, II, V, and VII. The Navajo Nation strongly and fully supports this legislation because it represents the collaboration of Native Americans working with the Indian Health Service to draft legislation that is truly representative of the needs and preferences of Indian people.

I would like to highlight some key areas regarding the preamble of 3397 on which we worked on titles I, II and III.

I respectfully request that members of this committee review and accept the Navajo Nation's written testimony which is appended and presented today.

The preamble was revised to reflect the trust responsibility of the Federal Government to fund and deliver health care to Americans and Alaska Natives. The Navajo Nation supports this reaffirmation of the special relationship between tribes and the Federal Government and urges the Federal Government to act with diligence to eliminate disparities between Indian programs and those of the U.S. population.

America's native population will benefit greatly from the amendment citing "Healthy People 2000" as the goal for Indian health care to be met by 2010.

The Navajo Nation is extremely pleased with the preamble's provision that requires Congress engage in consultation with Indian tribes, tribal organizations and urban Indian organizations.

We also favor the provision stating the funding for Indian health programs run by entities other than the Indian Health Service not be less than those run by the Indian Health Service.

The Navajo Nation strongly and fully supports more autonomy for local service areas under title I. Title I requires consultation with tribes, tribal organizations and urban Indian organizations in addressing human resource development and funding.

Indian Health Service scholarship recipients must meet service obligations in the areas awarding the scholarships and this will mean that traditionally underserved areas will benefit from medical professionals recruited by and provided to their own areas.

Title II eliminates the list of distinctive service and programs and expands on the programs offered Indian Health Service patients, including traditional healing practices.

The Navajo Nation supports this title along with the revision that provides for tribal input in programs devoted to preventive education and healthy lifestyle promotion. The Navajo Nation is also in favor of expanding diabetes and dialysis programs with permanent funding to counter the staggering rates of diabetes in Indian country. This is epidemic.

Environmental factors that affect Navajos are an important priority to the Navajo Nation. We support provisions to study and monitor programs that address the health issues of Indian minors and Indian communities that reside in environments that pose health hazards resulting in chronic and life-threatening ailments.

Tribal consultation and the establishment of health care facilities serving Indians is a vital component of self-determination.

The Navajo Nation supports title III, the assertion that tribes must be consulted in the establishment of the health care priority system and for the construction, renovation or closure of any IHS facility. We emphatically urge Congress to appropriate the necessary funding to replace or renovate health care facilities and to construct additional facilities and staff housing.

We also recognize the critical need for proper water and sanitation systems to promote better hygiene and health in the homes of Native Americans and Alaskan Natives.

In closing, the Navajo Nation believes that the current draft of the proposed amendment for the reauthorization of the Indian Health Care Improvement Act will significantly improve the quality of health services to native Americans and that it will improve the overall health of Indian and Alaskan Native people.

We respectfully urge this committee to assist in moving the proposed Public Law 94–437 legislation through the U.S. Congress. Thank you for allowing me to testify on behalf of the Navajo Nation.

[Prepared statement of Mr. McKenzie appears in appendix.]

The CHAIRMAN. Thank you, Dr. McKenzie.

Ms. Davis.

STATEMENT OF JULIA DAVIS, MEMBER, NATIONAL STEERING COMMITTEE ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT; CHAIR, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, PORTLAND, OR

Ms. DAVIS. Good morning, Chairman Campbell.

The CHAIRMAN. Are you shy?

Ms. DAVIS. You will have to excuse my voice. I have a cold.

The CHAIRMAN. There's a doctor sitting next to you if you want to ask for some advice. You are in good company there.

Ms. DAVIS. It is a pleasure to see you this morning and talk with you about the Indian Health Care Improvement Act. We were very pleased to see that this hearing took place.

As vice chair of the National Indian Health Board and chair of the Northwest Portland Area Indian Health Board, we were constantly writing and calling and asking the Senate Committee on Indian Affairs to have a hearing on this. So we do appreciate your effort to do this.

As was mentioned earlier, the draft bill is Senate version of the consensus bill that was developed by the tribes and this took place from May last year to October of this year.

We had a lot of work that took place in those work groups. What I am going to speak about to you today is the title III section which deal with facilities construction. I was cochair of that work group and I am pleased to report to this committee that we had a cooperative spirit of all the people that were involved in working on that section.

I think it is a strong section that, if passed as proposed, would vastly improve the sorry condition of the facility's infrastructure of Indian health programs.

Before I go over the proposed changes, I would like to just say a few words about Federal funding for health facilities.

Medicare and Medicaid provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare and Medicaid program.

Yet, American seniors receive care in the most modern clinics and hospitals in the world. Indeed, it is remarkable but true that poor Americans who are eligible for Medicaid in Washington, Oregon and Idaho now receive their care in the same facilities as other non-poor Americans. That's right, in the same very clinics and hospitals that are the envy of the world.

What about the Indian people? Their clinics, with notable exceptions, are old, on average more than 30 years old. My clinic in Lapway, ID is 40 years old. The clinic director has her office in a window-less office basement room.

Often, when one of our tribal members becomes eligible for Medicaid they chose to drive 20 miles to the border town to see a doctor in a modern facility and not at our clinic. The clinics are not just old, they are inadequate.

What explains the poor condition of so many Indian clinics? Unfortunately, it is the budget process itself that annually underfunds the Indian Health Service budget that is the cause of the poor condition of our facilities.

There is no doubt that again this year no progress will be made to address the backlog of facilities need. This choice is unfair. No one asks Medicare recipients if they want facilities or programs. They get both.

It is bad health care and bad business to have poor facilities. Because the Indian Health Service is a discretionary program, our funding is limited and proposals for facilities construction are the low-hanging fruit that is chopped off every year. In fact, I think it is wrong that we don't ask for more than we do each year.

I think that the proposed title III section has widespread support. In the Northwest we have presented the title to our board and at two special meetings in December and April, I can report to you that our tribes have not expressed any serious reservations on title III.

However, I would understand if some tribes would like to have more time to fully understand this section of the bill. I am happy to present this testimony and I will answer questions. Thank you.

[Prepared statement of Ms. Davis appears in appendix.]

The CHAIRMAN. Before we go on to Dr. Roubideaux, I might tell you Julia that this is not the first hearing. This is the second of three. We did one already. We are doing this one. We will be doing another one in July.

If you have been contacting the Indian affairs office, as you said you have a number of times, the staff is right here. It is not like this thing just started today. It has been going on. I would have thought that most people in the Indian communities would have been aware of it. This is a series of hearings.

In any event, I have to also say that one of the problems Indian people face around here, and as you probably know, this is a body that reacts to pressure and suggestions and all kinds of things.

When you mentioned the facilities that seniors get, AARP has about 4 million members and they know how to bring a lot of pressure on this body, as you probably know. One of the problems I think we have always faced is that Indian people tend to be often very stoic. They don't say anything. They sort of just take it.

They shouldn't. They need to get more involved. They need to be here to tell us what they want and what we need to do. So let that be a lesson when it comes time to participate in the process, to vote, and to call your Representative and so on to make your voice heard.

Dr. Roubideaux, go ahead.

STATEMENT OF YVETTE ROUBIDEAUX, M.D., PRESIDENT, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, OKLAHOMA CITY, OK

Ms. ROUBIDEAUX. Good morning, Mr. Chairman. My name is Yvette Roubideaux and I am the president of the Association of American Indian Physicians. I am a member of the Rosebud Sioux Tribe. I am a Harvard-trained, board certified internist with experience working in the Indian health system.

On behalf of the Association of American Indian Physicians, I would like to thank you for the opportunity to provide testimony and support for the reauthorization of the Indian Health Care Improvement Act.

I believe the Association of American Indian Physicians is now beginning to realize its role as a leader in improving the health of Indian communities.

We are a national nonprofit organization that was founded in 1971 by 13 Indian physicians. We now have approximately 300 Indian physician members. Many of our members have seen firsthand the health problems and challenges in Indian communities and the pressing need for more resources in all area of Indian health.

Despite being trained at the best medical school and residency program in the country, I faced significant sadness and frustration at the lack of resources, outdated equipment and facilities and shortages of high quality health care providers and staff.

Sadly, American Indians are also the most under-represented minority in the physician category compared to the general population.

We support the reauthorization of the Indian Health Care Improvement Act and its reaffirmation of the Federal trust responsibility and the sovereign rights of tribes to self-determination and self-governance

We also believe that Indian people deserve to have the opportunity to receive medical care from well-trained, culturally competent, American Indian and Alaska Native health professionals.

The major focus of our testimony today will be on title I, the Indian Health Resources and Development. We are grateful for the Indian Health Service Scholarship Program. I would not be sitting here today as a physician without the support that I received under sections 103 and 104.

However, while we agree that the scholarship program should be more responsive to local priorities and needs, we are not supportive of further restrictions on the location of pay-back obligations for the scholarship recipients to the area from which they received their scholarship funding. Placing more restrictions on pay-back options will further demoralize these individuals, worsen efforts at recruitment and retention and potentially result in placement in positions that do not match qualifications or career needs.

We strongly recommend that the current rules for pay-back should be retained and language that restricts pay-back to a specific area should be eliminated. The language that says "for special circumstances, a recipient may be placed in a different service area" is not strong enough and does not guarantee appropriate placement for these recipients.

We have also commented on the other titles in our written testimony. In title II, section 204, we support continued funding of the current model diabetes programs and programs funded under the Special Grants for Diabetes Program created under the Balanced Budget Act of 1997.

Funding for these diabetes programs must be continued through 2012 as the problem of diabetes in American Indian communities is reaching epidemic proportions and more resources and programs are needed to fight this growing problem.

In addition, we support retaining language to fund at least one area diabetes consultant for each service area and disagree with the current language to retain these positions at the discretion of each area.

We support all provisions in title III that would allow the construction of the high quality state of the art health care facilities for all Indian communities as soon as possible.

We strongly agree with the recommendation in title XI that the director of Indian Health Service should be elevated to an assistant secretary for Indian health.

We also strongly recommend that the position of the director of the Indian Health Service should continue to be filled by an American Indian or an Alaska Native physician.

On behalf of the Association of American Indian Physicians, I would like to thank the Senate Committee on Indian Affairs for the opportunity to provide testimony at today's hearing and to offer our organization as a resource to the Senate committee and the tribes and the Indian organizations involved in this process.

We encourage your efforts to help us achieve reauthorization as soon as possible. Thank you.

[Prepared statement of Ms. Roubideaux appears in appendix.]

The CHAIRMAN. Thank you. We appreciate that.

Ms. Dahlen.

STATEMENT OF BARBARA DAHLEN, ASSISTANT COORDINATOR OF THE RECRUITMENT AND RETENTION OF AMERICAN INDIANS INTO NURSING [RAIN], UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, ND

Ms. DAHLEN. Good morning, Mr. Chairman. It is an honor and a privilege to be here today to speak on behalf of the Quentin N. Burdick Indian Health Programs.

As you know, the Quentin N. Burdick programs come under the Indian Health Care Improvement Act. They are housed within the act. The Quentin N. Burdick programs contain the RAIN program, Retention of American Indians into Nursing, INMED, Indians into Medicine, and the INPSYDE Program, Indians into Psychology.

These programs are housed at the University of North Dakota and have been proven to be very successful in educating and retaining American Indians and increasing the number of health care professionals who return to Indian country.

The INMED program has graduated 122 graduates which consists of one-fifth of all of the American Indian doctors who work in the Nation.

The RAIN program, prior to 1990, had graduated 18 American Indian nurses. When you look at the College of Nursing itself that opened in 1948, so from 1948 to 1990, they could only boast 18 graduates. Since 1990, in the 10 years that the RAIN Program has existed, we have graduated 70 American Indian men and women with their Bachelors in Nursing. Since 1995, we have graduated 16 men and women with their Master's Degrees.

In that short span you can see the impact that the RAIN program has had, not only on the recruitment, retention, but also the graduation rate of American Indians who come to the University of North Dakota.

We have been recognized as a national model and now are internationally recognized as a model program for the Nation. We have been visited by the University of Australia School of Medicine. We have been visited by New Zealand for the Maori people to emulate

our program, to find out what we have done right and why we are retaining people the way we are and why people are coming to the University of North Dakota.

What I can say is that retention is labor intensive, it is a 24-hour job and it is the commitment. We have had the honor and privilege of working with the Indian Health Service and under the Indian Health Care Improvement Act.

We have formed partnerships with tribal colleges. In the past, when students would fail they would fail or drop out. They would just stop out. There wouldn't be any track record of what happened to that student, what went wrong, why did they leave the university. We track all those things.

In partnering with the Sisseton Wahpeton 2-year tribal program, instead of losing students for whatever reason we find that students sometimes need the ladder approach to success, so we send them into the 2-year RN program at Sisseton Wahpeton and they receive their 2-year degree. We track them to come back into the RN/BSN option track.

Without those efforts, without those partnerships, without going to the tribal colleges at Fort Berthold, at Fort Totten, at Fort Peck, we have indeed increased their pre-nursing curriculum and worked with those faculties at the tribal college level to say, you can prepare them in the pre-nursing arena for them to come to us indeed much better prepared.

When we start looking at retention efforts, we looked at conceptual frameworks that would help us. What we found out was that prior schooling, prior family background all impacted retention.

So, with these efforts we found that we had to look at our students in a whole different light.

We thank you for this opportunity. Again, it has been an honor and a privilege to speak before you, Senator Campbell.

We hope that our efforts will be continued with the ever increasingly shrinking dollars that we are working with. Thank you.

[Prepared statement of Ms. Dahlen appears in appendix.]

The CHAIRMAN. I thank you. Let me ask each of you a couple of questions.

Dr. McKenzie, we are a little bit confused about the designation of Arizona as a contract delivery system. Most of the Navajo people are in New Mexico or that proximity; are they not?

Mr. MCKENZIE. We have many Navajos in the metropolitan areas. Most of them still reside on the reservation.

The CHAIRMAN. More have gone to Phoenix than, say, Albuquerque?

Mr. MCKENZIE. I would say probably more in Phoenix, yes.

The CHAIRMAN. The Navajos who live off reservations, that are in urban areas like Phoenix, where do they get health services now? Do they usually come home?

Mr. MCKENZIE. There are several ways that they seek out health services. One, yes, is to come home and to use the Indian Health Service facilities.

In those cases where they made contact with the home health program, if they should encounter an emergency situation they would be eligible for contract health services from the home area,

but there has to be a well-defined relationship between that urban individual and the home base.

Then there are those that are eligible for the various health programs that the State provides and they are eligible to apply for that. Many of them do use the Medicare/Medicaid and children's health programs the States provide.

The CHAIRMAN. Those are open to everybody?

Mr. MCKENZIE. Those are open to everybody, yes.

The CHAIRMAN. Does Arizona have health care programs through the State that are specifically designed for urban Indian people?

Mr. MCKENZIE. No.

The CHAIRMAN. They do not.

Ms. Davis, speaking about urban Indian people, there is a bigger increase of Indian people going to the city. They need jobs, so they migrate to the city. I was interested in your view on the proposed definition, the new definition of Indian in the bill.

We have always had a problem with that, as you know. We deal with it in arts and crafts and medical services and everything you can think of. Would this have an effect on the number of people that get help in urban areas? How would you define who should avail themselves to those services? Is it just being enrolled or what?

I mean, you know, we have blue-eyes blondes that are 1/160th, but legally they are Indians because of the lineal decendency that some tribes use. I remember one bill years ago where a person was 100 percent Indian, but he was eight-eights so he was not on anybody's roll.

So, legally, according to the Government definition of who is an Indian, he was an Indian but, you know, every one of those tribes had a one-fourth or more provable ancestry requirement.

Ms. DAHLEN. Chairman Campbell, I am so glad that you asked that question, for the fact that the Indian Health Care Improvement Act Committee, the leadership committee, had a lot of discussion on entitlement.

One of the proposals that we have in the Indian Health Care Improvement Act is to form an entitlement study commission to look at that very issue on eligibility.

We knew that it would be a hard decision, that it would be hard because each tribe has their own enrollment and their own eligibility and we would be stepping on toes, but we really felt strongly that we needed to address it.

So that is one of the recommendations.

The CHAIRMAN. I think it is a good idea. I don't know, it may come in conflict with what some tribes see as tribal sovereignty, but it might be a difficult thing to do.

I remember one man who testified on a bill. He was Hopi on his dad's side. Apparently, in the Hopi roll, you can only be enrolled if the ancestry comes from your mother's side. It is a matriarchal society. So you could be the same amount of Indian, but depending on which parent was enrolled, you might or might not be able to get on the Hopi roles. I think it could create a problem on this, too.

You also had some views on cultural training. Title I of this bill requires that appropriate employees receive instruction in the cul-

ture and history of tribes. I think that is really important for those tribes that have very strong traditions.

I know I have had Navajo friends tell me that their spiritual leaders often work with the medical profession in trying to diagnose or trying to help people. I have seen that with other tribes, too.

My question would be, who is deemed appropriate? I recognize that there is some importance, but how do you define who is appropriate? Is it tribe to tribe to determine that? Who within the tribe determines it?

Ms. DAVIS. The traditional healer?

The CHAIRMAN. Yes; if they are going to be appropriate employees who receive instruction in culture and history——

Ms. DAVIS. Okay. What we have done, and I will give you an example from our tribe, what we do is like cultural sensitivity training. We have people that come from back east, back here as a matter of fact. They come out there and they have no idea. They still think that the native people live in tipis, that they still run around with their horses and things.

So, we do have to have cultural sensitivity training for them and explain to them the traditions and the heritage of our tribe. I know that other tribes do that, too, but it is really needed, really bad.

The CHAIRMAN. This has nothing to do with that, but years ago I was up home visiting where I am enrolled in the Northern Cheyenne. At a little gas station a carload of tourists came through and they must have been out of gas or something. They pulled up at the gas station and the guy driving rolled down the window just a little crack. He said, "fill it up" and rolled the window back up real fast. I got the impression that he had been watching too many 1930's movies.

Traditional healing practice as discussed in title II would be integrated into modern health services. I would assume that those healing practices would be intended not to replace medical services, but to advise and try and coordinate traditional beliefs. Is that your view?

Ms. DAVIS. Yes; we did talk about it in our leadership group. We felt that traditional healing was very, very important for all of our native people. I know that Dr. McKenzie has some other important information on that.

The CHAIRMAN. Would you like to add to that, Doctor?

Mr. MCKENZIE. Thank you, Julia. Senator Campbell, I appreciate the opportunity to respond to that. Traditional healing is very much a part of the health care system of the Navajo people.

I have had an opportunity to kind of take a look at the two health care systems side by side and they are very similar. I think that perhaps maybe it is the logic of the thinking that makes them very similar in their approach.

So, I consider the traditional healing practices a science because it fits that description So, it should be very much a part of the health care system, even to have it available within the inpatient facilities as well as the outpatient facilities.

Some of our facilities do have an office for traditional health care practitioners to advise patients as they come to the clinics and should be very much a part of the health care system.

The CHAIRMAN. Do you find in the Navajo culture that the elderly people believe or rely more on the traditional methods than, say, the young teenagers within the tribe?

Mr. MCKENZIE. They are not rigid like that. There are cross-referrals. When a traditional healer feels that he has encountered something that is not amenable to native healing practice solutions, he will refer that patient to a western practitioner and vice versa.

The CHAIRMAN. I see. Thank you.

Maybe one last question to Julia. We have to be able to pay for things around here, as you know, Julia. We are always looking for some creative ways to find the money. If we have a revolving loan fund, do you have a ballpark figure on what we are going to need to get this program going? Have you done any study of that in your group?

Ms. DAVIS. Just off the top of my head, one of the figures that we were thinking about to at least get us started was like $100 million for facilities, because there is such a need, Chairman Campbell, for facilities.

I know that you do travel across Indian country, but the clinics, if you would go there, some of them are just trailer houses and old facilities that have not been upgraded.

The CHAIRMAN. Yes; I visited some. Even when we get a new building occasionally putting the facilities in the building is a whole other structure. The building in and of itself doesn't heal anybody. You have to have the equipment and the knowledge and so on. All right. Thank you.

Dr. Roubideaux, for my own information, how many Indian physicians are there now in your association? What percent do you think got their medical training through some form of scholarship?

Ms. ROUBIDEAUX. There are currently about 300 members of the Association of American Indian Physicians. I would have to estimate about one-third of them got the Indian Health Service Scholarship.

The CHAIRMAN. Were you raised at Rosebud?

Ms. ROUBIDEAUX. I was raised in Rapid City, SD.

The CHAIRMAN. Rapid City?

Ms. ROUBIDEAUX. My father is from the Rosebud Reservation and my mother is from the Standing Rock Reservation.

The CHAIRMAN. As I understood your testimony, I was trying to jot some notes here, and you apparently don't particularly support the payback restrictions; is that true?

Ms. ROUBIDEAUX. Yes.

The CHAIRMAN. I don't know how we are going to deal with that. Let me just put it this way: If you go in the military and you want to be a doctor, you have no money but you want to be a medical doctor, you can go to the military, for instance, if you get through an academy and they will actually send you to medical school, as you probably know, after you graduate West Point or one of the academies.

But they will only do it, because they are going to have a terrific investment in you as a young military person, so you have to sign an agreement saying that you will give them so many years back for the training and the money that they put into you.

It would seem to me that doctors, I don't know for sure, but I heard Ms. Dahlen's testimony about the number of nurses that go back to Indian country. She said something like 90 percent, which I think is great.

Do you know what percent of Indian people who get their medical degree go back to Indian country as opposed to the ones that move to the city where there is better money and, you know, let's face it, we all have to make a living.

Ms. ROUBIDEAUX. Right. A significant number of our members worked in the Indian Health System or tribal urban programs at some time in their career. For example, of the current 300 members, 200 members, in a recent survey, said that they worked in the Indian Health System at some time.

Currently, however, only 69 of our members work in the Indian Health System.

The CHAIRMAN. Well, to me that is a way of paying but. But that is voluntary. They decided to do that themselves, which is good. But you are really opposed to a requirement that they do it?

Ms. ROUBIDEAUX. No; I don't' want you to misunderstand, Mr. Chairman. I am supportive of, if a physician signs a contract, they need to pay back that scholarship in the Indian Health System.

However, in the bill the language has been changed so that they have to pay it back in the specific area where they got the scholarship. I think that is too restrictive.

The CHAIRMAN. Yes; I see.

Ms. ROUBIDEAUX. I think that is too restrictive. When I was a scholarship recipient, I got my funding through the Aberdeen area, but when I graduated my residency, there were no suitable positions for my training in the Aberdeen area. I was trained as an internist and I would have had to do things outside of my specialty if I had to go to the Aberdeen area.

Fortunately, there was a wonderful position in the San Carlos Apache Reservation where I was able to use my skills, both in internal medicine and in administration and management and it was a wonderful opportunity. So, I am just asking for some flexibility.

The CHAIRMAN. So, that requirement would hinder physicians from going on to further training because they might be in an area where there just isn't any opportunity for them to specialize.

Ms. ROUBIDEAUX. It may hinder further training, but it also will hinder their ability to practice their specialty. A pediatrician may be sent somewhere to be a family doctor. I don't think it is right for pediatricians to be seeing adults if they are not trained to do that.

So, I believe there should be as much flexibility as there currently is in the Indian Health Service scholarship program where you pay back in an area of need where there is an opening, anywhere in the country. It is up to the areas to recruit the doctors that they need and to attract them to come to those areas.

The CHAIRMAN. Well, I guess Indian country is like a lot of non-Indian country and that is small, rural areas, farm towns, for example, have much more difficulty recruiting physicians as you know.

I would guess that Pine Ridge has more difficulty than a reservation that is next to a big city as an example. We need to find a way

that we can encourage people to go to places that might not be their first choice.

Ms. ROUBIDEAUX. Absolutely. I think if there were some provisions in title I that supported recruitment and retention efforts at some of the higher need facilities, for example recruitment and retention bonuses, and made that process a very easy process, then you would get more physicians choosing to go in the highest need areas.

The CHAIRMAN. Thank you.

Ms. Dahlen, you have a total of 43 students currently enrolled; is that what I understood you to say?

Ms. DAHLEN. That is right, correct. They are currently enrolled at this time.

The CHAIRMAN. I am interested in the tribal colleges, partly because I am on the American Indian College Fund board and help with them.

It sounds like you had some very good collaboration. Can you explain just very quickly how the programs are integrated with the university to successfully train health care professionals?

Ms. DAHLEN. How the tribal programs are?

The CHAIRMAN. Yes.

Ms. DAHLEN. For instance, we have worked extensively with Belcourt in order to create a pre-nursing curriculum so that as the students who identify their choice of nursing as a career option can go to the Turtle Mountain Community College or the Fort Totten——

The CHAIRMAN. You try to get it accredited?

Ms. DAHLEN. We try to get the curriculum so that all the credits are transferable so that teachers who are teaching it have the credentials to teach it.

The State Board of Nursing requires certain classes be taught by Master-prepared nurses. So we bring all that information to them. We bring curriculum. I, myself, look at the curriculum.

I sit on the Curriculum Committee in the College of Nursing so I can look at the Tribal College curriculum and I can look at our curriculum and I can say to them, "This course is strong enough. It will come in" or "This course is very strong in this area but perhaps weak in this area. If you strengthen it, we have a change of getting it in and getting it transferred."

By doing that at Totten, at Belcourt, at Fort Peck, they all have very strong pre-nursing curriculums. The tribal college at Sisseton Wahpeton has an excellent 2-year RN program where we are now sending students, like I said, to transfer into that program if we find they are not going to make it at the 4-year level initially. It gives them a starting point.

Fort Berthold has a 2-year LPN program. When we went to Fort Berthold they had a very high failure rate on their boards for NCLEX examination of their nurses. With working with them and developing a preparatory program for them to prepare them for boards, they are up in the 90 percentile for board pass. On the NCLEX examination, all of our students have passed their boards and are working.

When I say 90 percent of our nurses have remained in Indian country, that is 90 percent after obligation is fulfilled. Nurses stay.

We have tracked both physicians and nurses and we have looked statistically at who stays in Indian country, it is the nurses who stay the longest.

That is why the need for nurse-practitioners and funding for nurse-practitioners and nurse-midwives is so important, because they stay so long. They do their obligation and they go back home and they are wives and mothers, and yet we have those long-term commitments.

The CHAIRMAN. We would have you give the secrets of your success to Dr. Roubideaux and the physicians, too.

I thank this panel very much for appearing this morning. Thank you.

We will now move to panel 2, Jerry Danforth, chairman of the Oneida Tribe of Indians of Wisconsin, and Douglas Eby, M.D., the vice president of Medical Services for the Southcentral Foundation from Anchorage, AK.

We will go ahead and start with Jerry Danforth please, and then we will proceed with Dr. Eby.

Mr. Danforth, please go ahead.

STATEMENT OF GERALD DANFORTH, CHAIRMAN, ONEIDA TRIBE OF INDIANS OF WISCONSIN, ONEIDA, WI

Mr. DANFORTH. Chairman Campbell, members of the committee, good morning. My name is Gerald Danforth. I am the chairman for the Oneida Tribe of Indians of Wisconsin, representing about 14,000 members.

I thank you for this opportunity to appear before you today. I would like to discuss two points: First the Oneida's participation as one of the delegates to the National 437 Steering Committee. As a participant on the steering committee, the Oneida Tribe took great interest in contributing to the redrafting of title III, Health Facilities, and title IV, Health Care Financing.

Second, I would like to take the opportunity to address the current shortfall in funding for new health facilities, its impact on the health of Oneida members, and a proposed innovative solution to that problem.

In June 1999, the Indian Health Service convened a National Steering Committee made up of IHS, Indian governments, and urban Indian organizations. The initial plan for that steering committee was to develop broad concepts and general ideals for the distribution of Federal funds for Indian health.

After the initial meeting, however, that steering committee decided to tackle redrafting in a comprehensive way, the Indian Health Care Improvement Act. That was based on consensus recommendations developed at four regional consultation meetings.

The final proposed bill was presented in October 1999 to the Director of Indian Health Services and to each authorizing committee in the House and Senate.

The Steering Committee allowed the Indian Nations of the United States, including the Oneida Tribe, to have a powerful voice in that amendment and renewal of preeminent Indian health care law.

The Oneida Tribe fully supported and continues to support Indian Health Care and the Improvement Act Reauthorization

Amendments as the most feasible solution for the advancement of Indian health.

With regard to my second point regarding construction of new health care facilities, we are strongly in support of the reauthorization of the Joint-Venture Program. Under this program, tribes will be able to finance construction of adequate facilities if His will equip and staff the facility.

The Oneida Tribe, along with other members of the tribal nations Joint-Venture Coalition are working to develop and construct facilities with funds that they would generate by bonding or through promissory notes.

If IHS were to assume the cost associated with equipping and staffing these facilities, it would be possible to construct appropriately sized and equipped facilities to provide adequate health services. Such funding is already authorized in law as the Joint-Venture Demonstration Program. The proposed amendments shorten the no-cost lease to the IHS provisions in the joint venture.

With adequate funding for the joint venture program, three or four tribes annually could complete the construction of their facilities, putting them up to 60 years ahead of schedule. I come up with that because under the current need there is a need for $938 million for new construction of health facilities in Indian country.

In considering the current funding levels, those tribes who have managed to secure a spot on the very exclusive IHS health construction priority list could have up to a 60-year wait for that facility to be built.

As a consequence, the existing health facilities are outdated, difficult to maintain, inadequate, and in desperate need of replacement.

In Oneida, our health department struggle to meet the demands of an increasing population of aging, of an aging building that is far outdated, we have three trailers currently that are placed on our property to provide our health care needs to the citizens of our community.

Our patient rate is growing. It has increased over 9 percent over the past 7 or 8 years. We have a growth in our departments and our enterprises and businesses and programs that we have on the reservation. As a result, we have a number of members moving back to the reservation. So, our population has grown immensely in the last 10 years and is projected to continue that growth in the immediate years and the projected long-range growth as well.

The bottomline on the Joint-Venture, we see the Joint-Venture Program as the needed booster shot to take us over the hump, and in the out-years we envision the possibility of even third-party billing to be able to become completely self-sustaining through this program.

But in order to get there, this Joint-Venture Plan would be the necessary means to achieve that goal. So the Oneida Tribe strongly encourages you to support the funding for the Joint-Venture Program. We also ask that you encourage your colleagues on the Appropriations Committee to do the same.

Thank you very much for your time and attention on this matter.

[Prepared statement of Mr. Danforth appears in appendix.]

The CHAIRMAN. Go ahead, Dr. Eby.

STATEMENT OF DOUGLAS EBY, M.D., VICE PRESIDENT OF MEDICAL SERVICES, SOUTHCENTRAL FOUNDATION, ANCHORAGE, AK

Mr. EBY. It is an honor to be here today. I am also honored by your correct pronunciation of my name as you did. Only having three letters, it is pronounced many different ways.

I come as vice president of a native-owned private corporation that is located in Alaska, in Anchorage, in the land of the Denina. I come to you on behalf of the Southcentral Foundation Board, our president/CEO, Katherine Gottlieb, the corporate vice presidents and the staff of the corporation.

My goal is to give you a real life example of what we have been able to do under native ownership and native management, and not really speak to the general provisions of the Health Care Act.

In Alaska, the entire State, the large Indian Health Service-run program in the State of Alaska is now completely native-owned and completely native-managed. Some people are very proud of this. This allows us to be more locally focused and more culturally appropriate. It allows us to get at issues of respect and dignity and to decrease issues of dependence in the Alaska Native community.

It has increased our ability to partner with other organizations since we are no longer a Federal agency. It has allowed us to combine funding sources and to pursue other funding sources such as contracts, grants, and so forth and extend the moneys that we are given through the Indian Health Service funding stream.

Some of the examples of what we have been able to do despite providing service to 350,000 outpatient visits in the last year and despite having relatively inadequate funding, we have been able to do some exciting things. We would invite you and anyone else who wishes to come visit us.

Right now you can choose your own primary care provider. We guarantee you seeing that primary care provider today for anything you want to see that primary care provider for; today, in the way you want to see them, in the way you want the information, whether it be by phone or in person or in a group setting or through a case manager.

We do everything we can to connect the same primary care provider and the patient over time. We have been able to increase by three-fold the connectivity of the patient and the primary care provider and we have decreased our no-show rates from 25 percent down to below 5 percent.

What we have done is follow Native leadership, native management and the customer. As a customer-owned system of care, we are constantly talking to the customer and changing our system to be in the way that our customers want it to be.

Part of the way we have done this is an unyielding access priority. If you build a good system and the people can't get in, it is not worth anything. So, access is our primary cornerstone.

The other thing is, the people who come to our services come for their life and often for generations. So we build a very relationship based system where you see the same provider, where you get consistent messages, where you work in partnership on the ability to learn and to do more self-care become a central priority of the sys-

tem, again increasing issues of respect and dignity and decreasing issues of dependence.

We have mandated population-based thinking in our clinics. Part of the other thing that we have done is what some of the other people have spoken to today, is Native development, Native professional development and we have moved now native managers into day-to-day management of every single clinical program we have.

When we took over the system at Alaska Native Medical Center, the portion of it we have, 2 years ago there were hardly any native managers. We now have 35 native managers in the pipeline coming up through the stream.

Despite decades of management, the Alaska Native Medical Center, as it is transitioning right now at the senior positions there is a paucity of eligible, qualified, and experienced native managers. This is something that has got to change.

When you put the system into customer-owner hands, you start to get that priority because it is a very strong priority in the native community.

Facilities is another things that we see as important. We have done very many creative things partnering with our for-profit corporate partners and other people in the community to try to find those precious facility dollars.

There are a lot of things Indian Health Service does not provide funding for and has not provided structural support for that our native leadership feel is important. Service to adolescents, Anchorage is a fairly urban environment.

The statistics around the transition from school to adult life in the native adolescent population, the statistics are abysmal and it is a focused, targeted area that our native leadership have said they want to focus on, but it is not something that there has been any attention to in the Indian Health Service funding stream or structures that we have inherited.

Another issue is elders and long-term. Another priority for our board is hospice care, allowing native people to spend their last months or year with their family in the way they want to, again, something that has not been a part of the historical IHS funding stream.

So, as we have moved to native management we have done a lot of things. We are building toward long, term sustainability. We have found ways to be much more efficient.

Utilization rates are dropping while no-show rates are dropping. But our effectiveness is going up and our patient satisfaction and provider satisfaction are climbing rapidly as well.

It is a system that builds on the strength of all of the different pieces and allows us to get to issues of prevention and wellness in effective ways. It is culturally appropriate. It is native-run. We have mandated training for all of our staff on natives.

It is increasing dignity and respect while decreasing issues of dependency in the community. We come as strong supporters of native self-determination, the transition to Native management and the support of the Indian Health Care Reauthorization Act as one of the tools to get there.

We feel strongly that native management can do it and has a strong, proven track record in areas where there has been the possibility of doing so.

Thank you for your time.

The CHAIRMAN. Yes; thank you. Let me ask you a couple of things, Dr. Eby. I have been to Alaska a number of times with Senator Stevens and Senator Murkowski. It is a beautiful State, but it does have huge distances, some weather variance. The last time I was in Barrow, it was 42 degrees below zero. You certainly have some transportation problems.

You talked in your testimony about same day service. Given those limitations, how does the Southcentral Foundation manage to do that?

Mr. EBY. Southcentral Foundation provides primary care services to the urban population of about 30,000.

The CHAIRMAN. Is that primarily around Anchorage?

Mr. EBY. Then there is another 12,000 that are village based. For the village-based population there is the health aid system which you may be somewhat aware of. Part of what we are doing right now is putting more and more technology in their hands so that we can actually see pictures and have more real live interaction.

The other things we have done is create a Native Advisory Board for those villages that give us advice and tell us how they want the services delivered and where they want them delivered.

The CHAIRMAN. In your Anchorage Service Unit system of care, is that a mobile system? In my notes you have a rural service unit in Alaska that is called an ASU or Anchorage Service Unit; is that correct?

Mr. EBY. Yes; there are 55 villages for which we are the primary care hub. Our eyes, our ears, our hands in those villages are the community health aides. There are two to four in each village. Then we have some regional hubs that are staffed by PA's and Nurse Practitioners. Then all that feeds into the physician-based systems.

We do send our physicians out two to four times a year to every single village. We send dentists out. We send optometrists out. But a great deal of what we do is over the phone and through the providers that are based in those locations.

The CHAIRMAN. I know unfortunately there is a high incidence of alcoholism among the native communities in Alaska. How do you integrate your health care with those injuries or problems that have alcohol-related origins.

Mr. EBY. Alcohol is a symptom of many deep-rooted causes, I am sure is not surprise to you.

The CHAIRMAN. Sure. Certainly.

Mr. EBY. Part of the reason we have built this things the way we have is that medical systems in the past have tended to deal with what the acute issue is, what that superficial layer is. It is sort of putting band-aids over a gaping wound.

By going to a more relationship-based system where the same nurses and the same doctors are dealing with the patient, the same family, and the same community over and over and over every time, you start to be able to get to the root causes. You start to

get to issues of depression, to violence, to family dysfunction, to substance abuse of all sorts, tobacco.

If you have a system where the providers are just interchangeable and you send one this time and someone else another time and someone else another time, you start at the beginning of the patient's story every time.

If you create a longitudinal relationship-based system, every visit builds on the previous one and you start to get to the underlying issues and quit treating the symptoms and start to treat the root causes.

The CHAIRMAN. Thank you. Also, in the former panel we discussed just a little bit about traditional healing and the involvement of traditional healing. I would assume that is very important with the Native Alaskan peoples, too.

Can you give me a couple of examples of how that works, how you integrate traditional beliefs and healing with modern science?

Mr. EBY. Right. In the last couple of years we have made a lot of advancement. In the past in Alaska they were kind of held at arm's length. Again, under tribal management it has changed completely, the philosophy around that.

We have a tribal doctor at Alaskan Aid Medical Center now. Part of the way we have worked out the interface is we have used a lot of terms that are familiar to medical people, so there is credentialling and privileging, but it is done in the Native traditional way.

We have a group of elders who sit in the room with the healer, feel their spirit and pass judgment on whether that person is going to represent them in the medical setting, not whether they are a traditional healer in the community, but whether they are accepted by the Native community as a tribal doctor in an approved, paid medical setting.

Then we work strongly with the medical staff and have pretty much fully integrated and a great deal of the credit goes to the traditional healing community themselves for being open to that interface.

The CHAIRMAN. Thank you. The last time I was up there, Senator Stevens and I and several others were in a little helicopter out of Barrow looking at the surrounding countryside. We came up over a rise and there was the biggest, most beautiful white bear I ever seen. He dove and took off.

We just went over the next rise and there was a man with a sled and a gun who was sneaking up on that bear. He was very unhappy with us. He waved at us. At least I think it was a wave.

Chairman Danforth, let me ask you a couple of things, too. Under the Joint-Venture Program, would the tribes being willing to assume partial cost for staffing for a facility which eventually would be assumed by the Indian Health Service?

Mr. DANFORTH. I think we would be open to negotiate those sort of costs associated with that, sir.

The CHAIRMAN. You mentioned the backlog of construction. We are well aware of that. As you probably know, the problem we have, of course, is that we are mandated by a budget resolution that we do not spend over a certain amount of money.

That is how we managed to get this terrible deficit under control after two decades of spending more than we took in. So that means there is a terrific tug of war around here, as you probably know.

When we try to put more money into one part of the budget, we are mandated to have what are called "offsets," to find it somewhere else in the budget, to take it out of some other thing. It is very difficult to do.

Through the Interior Appropriations Committee, I sit on that committee with Chairman Gorton, I think, as I understand it, we are going to put about $15 million more into the Joint-Venture section. I think he is supportive of that. It probably still is not enough. We are trying to do the right thing. Fortunately, we have several other members of this committee that are also on that Appropriations Committee. So, we will be trying to do our best. I just wanted you to know that.

Well, I have no further questions, but I certainly appreciate your being here.

For those of you who want to have some input to this particular issue, we are going to keep the record open for 2 weeks. So, if there is anything you would like to add, Dr. Eby and Chairman Danforth, I would appreciate that.

If anybody in the audience would like to extend other comments, we will keep the record open for 2 weeks.

We will also probably followup with some questions in writing, too, that may be of a technical nature.

With that, I thank you. This committee is adjourned.

[Whereupon, at 11:02 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

In exchange for the session of millions of acres of tribal land, the Indian nations purchased the first pre-paid health care plan and the United States assumed the responsibility for the provision of comprehensive health care services to all American Indian and Alaska Native citizens.

Since its enactment in 1976, the Indian Health Care Improvement Act has served as the cornerstone for the provision of health care services in Indian country, initially by the Indian Health Service, and currently, as the foundation for a three-tiered health care delivery system that includes reservation-based tribally operated health care programs and urban Indian health care programs.

However, while much progress has been realized in achieving the act's objective of raising the health care status of native people to the "highest possible level", the unmet health needs of the American Indian people today remain alarmingly severe, and in some instances, the health status of Indians remains far below that of the general population. For example, Indian people suffer a mortality rate from diabetes that is 249 percent higher than that for the United States all races; a mortality rate from pneumonia and influenza that is 71 percent greater; a tuberculosis death rate that is 533 percent greater and a mortality rate from alcoholism that is 627 percent higher than the rate for all races in the United States.

Today we will consider titles I, II, and III of the Indian Health Care Improvement Act. The changes and modifications that have been proposed to these titles hold the potential for improving and enhancing the ability of tribal health care programs, urban Indian health programs, and the Indian Health Service to provide comprehensive primary health care and public health services to all eligible American Indian and Alaska Native people.

I join the chairman in welcoming all of the witnesses to this hearing. We look forward to receiving your testimony.

Testimony on Proposed Legislation to Reauthorize the Indian Health Care Improvement Act P.L. 94-437

Senate Committee on Indian Affairs
May 10, 2000

Presented by
Taylor McKenzie, M.D.
Vice President of the Navajo Nation

Thank you for the opportunity to present the Navajo Nation's position on the proposed legislation reauthorizing the Indian Health Care Act of 1976 also known as Public Law 94-437. As a former surgeon on the Navajo Nation, it gives me great pleasure to outline recommendations for the reauthorization of this important piece of legislation.

In early 1999, Indian Health Service (I H S) sponsored a series of regional meetings between health care providers from tribal and urban Indian healthcare programs to discuss specific healthcare concerns in Native communities and make recommendations regarding the reauthorization of the Indian Health Care Improvement Act, due to expire in September of this year.

In June representatives from tribes, tribal organizations and urban Indian organizations (I/T/Us) formed the National 437 Steering Committee. Charged with addressing the recommendations and conflicts from the regional meetings, the committee drafted the proposed reauthorization legislation being considered today.

The following areas of the proposed legislation are supported by the Navajo Nation:

Scholarships - Title I - Sections 2 and 3

The Navajo Nation concurs with assertions made in this Section that the United States government has a responsibility to ensure that the health of Native Americans is up the standards outlined for the rest of the population in its "Healthy People 2000" declaration. The Navajo Nation supports this section in recognizing the need for more Native American

healthcare providers and the stipulations of this section that provide for equal funding for tribally operated healthcare facilities as is provided for I H S facilities.

Title I of 94-437 gives a higher degree of autonomy to ITUs in that it provides for funding for I H S scholarships to Indians as described in Section 4 of this legislation to be funded through area offices. That individual service areas will award scholarships and service contracts will be fulfilled in the areas providing the scholarship unless otherwise agreed to, gives a higher level of control to ITUs in being able to plan for their healthcare needs and select their providers. It also means that more scholarships will be provided for federally recognized Native Americans, thus ensuring a higher degree of commitment from health care providers under these scholarships. Title I also provides for scholarships for a wider range of healthcare professionals. The Navajo Nation in recognition of the wide variety of health care providers ranging from physicians and nurses to community health representatives and pharmacists to drug and alcohol counselors and health educators, supports this increase in healthcare opportunities for Indian people. Navajo Nation also recognizes the need for a higher degree of cultural relevance in services provided to Indians. Section 117 of Title 3 requires tribal consultation in the design and delivery of training in the culture and history of the tribe scholarship recipients are to serve as an important step in ensuring that Native Americans receive care from Indians who are aware of cultural ramifications that might affect the quality of care given and the patient's receptivity to both the provider and the health solutions he or she offers.

Environmental Health/ Title II - Section 215

Section 215 calls for study and monitoring programs to determine trends that exist in health hazards posed to Indian miners and Indians on or near reservations and in Indian communities as a result of environmental hazards that may result in chronic and or life threatening diseases. The Navajo Nation supports consultation with tribes and tribal organizations regarding these

trends and stresses the importance of consultation as it allows tribes to take part in their destinies and is a true step toward self determination.

The Navajo Nation also supports the inclusion of studies with summaries of findings, reports and plans of action. A task force comprised of leadership from pertinent agencies will administer the plan. The Navajo Nation approves of the defined composition of this panel due to its ability to scrutinize data accurately and make educated determinations regarding Navajos affected by environmental hazards while in employment situations.

According to this facet of the reauthorization of P.L. 94-437, Indians who suffer work related illnesses or conditions as a result of uranium mining or milling will be eligible to receive diagnosis and treatment from an I H S facility. Medical care will be paid for by the owner of the facility responsible for the environmental hazard. The I H S can request reimbursement from such entity. This section does not nullify the right to recover damages other than medical expenses. The Navajo Nation supports this section because it provides for the compilation of accurate data regarding environmental health issues among Navajos along with components for education, prevention and treatment while requiring the entities charged with causing the health problems to take responsibility and rectify the damages.

Contract Health Service - Title II - Section 216

Another area of concern to the Navajo Nation is the retention of Arizona as a contract health service delivery area. At present time, the State of Arizona is designated as a contract health service delivery area by the I H S. Arizona must continue as a contract health service area until the end of Fiscal Year 2012, providing services to members of federally recognized tribes within the state. Services to Indians on reservations in Arizona will not be curtailed under this section. The Navajo Nation supports Section 216 because of the large numbers of Navajos living in urban areas such as Flagstaff, Phoenix, Tucson and other non-reservation areas. I H S

facilities are often difficult for Navajos living in these areas to access. This is especially true in critical care situations.

Facilities - Title III

This Title concerns monies spent on construction and or renovation of I H S facilities. Title III stipulates that the Secretary of HHS acting through I H S shall consult with the tribe that will be significantly affected by the facilities expenditure for the purpose of determining and honoring tribal preferences concerning that facility. The Secretary and I H S are to ensure that the proposed facility meets the construction standards of a nationally recognized accrediting body not later than a year after construction/renovation.

The Navajo Nation supports this Title and acknowledges the importance of local input regarding federally run facilities in related areas. Without tribal input regarding construction and renovation of facilities, there exists a concern that monies earmarked for such construction costs will not be spent in ways consistent with tribal needs or preferences and that additional expenses will be incurred when efforts to correct these issues are undertaken. The hiring of Navajos in the building trades is also an important issue in the Navajo Nation. Tribes must be consulted prior to the undertaking of any construction or renovation projects situated on tribal land and or servicing a majority Native population. This is consistent with the principles of self determination and is often a term of the funding provided for the facility.

Priority System - Section 301(c)

I H S has never been fully funded and therefore, must prioritize projects to ensure eventual completions. This section of the Indian Health Care Reauthorization Act establishes a health care priority system along with tribes and tribal organizations. Under this title, highest priority will be based on the needs of tribes. A list of the planning, design, construction and renovation needs will be established. The top ten priority inpatient care facilities, outpatient facilities and

specialized care facilities will be listed along with justifications for the order of the priorities, the projected costs and the methodologies used will also be listed.

The above-described methodology will include consultations with tribal governments and tribal organizations and a review of total unmet needs. This Section is important to the Navajo Nation because it requires more consultation with tribal governments prior to establishing priorities that affect Indian communities, an important component of self determination.

While outlining a priority system designed to address critical healthcare needs in Indian Country, there exists nothing in this section that stipulates a time period in which Indian healthcare needs will be met with the goal of ensuring that all communities in need will have facilities built and in operation by a specified date, the Navajo Nation encourages Congress to appropriate additional funding to build and or renovate health facilities serving a majority Indian constituency and to establish dates of completion so communities can project patient numbers, staffing needs, etc.

Comprehensive Behavioral Health Program

The Navajo Nation is in full support of the new provisions under Title VI to develop and operate a comprehensive behavioral health prevention and treatment program which places emphasis on collaboration among alcohol and substance abuse, social services and mental health programs. Revisions clarify that the Indian tribes and tribal organizations have responsibilities to develop plans which provide for a wider range of behavioral health services for families and individuals. These services can include but are not limited to community based prevention, early intervention, outpatient and behavioral health aftercare, acute hospitalization, transitional living, traditional health care practices, parenting education, youth programs, etc.

Data suggests a link between substance abuse, domestic violence, accidental death and a variety of other health issues present in reservation communities. The unification of programs under one banner is not only consistent with Navajo cultural practices, but will streamline the

assessment process and enable mental health providers to better serve their clients in a more cost effective way.

Non-Service Funds for Renovation - Section 305

Section 305 requires that the Secretary of Health maintain a separate priority list for increased funding for staff, equipment or other operating expenses supported by the tribal government. The Navajo Nation recognizes that an important component of the building of I H S facilities is the inclusion of funding for staff quarters, infrastructure and administrative costs for I H S facilities and or tribally run health care facilities. Medical facilities in Indian Country are often located in rural areas with few if any rental properties, either residential or commercial available. This is a strong concern in the recruitment and retention of qualified medical providers and support staff.

Joint Ventures - Section 312

The Navajo Nation supports Section 312 of the proposed legislation, which provides for I.H.S./Tribal Joint Venture Programs. Under this section, tribes can enter into joint ventures where tribes lease the facility for ten years to I.H.S., at no cost, and I.H.S. provides monies for staffing and equipment. Given the difficulty in finding funding for health care facilities and the enormous backlog on the I H S list of priorities, the Navajo Nation is in support of Section 312 as an innovative way to meet the healthcare facility needs of the Navajo Nation. However, there are instances where tribal governments are not in the financial position to provide matching funds to I H S projects. The Navajo Nation supports additional congressional funding to match these funds in instances where the tribal government is not in the position to do so.

Third Party Payors - Title IV

Many Native Americans are eligible for programs that provide healthcare to Indians under other federal and or state programs. In many I H S facilities, the operating budget consists of 50 to 60 percent funding from third party payors. Efforts to enhance collections enable these facilities to better plan for and provide services to clients.

Title IV of 94-437 enables I H S, tribes, tribal organizations and urban Indian Organizations to bill Medicare, Medicaid and Children's Health Insurance Program for services provided to Indians under the Social Security Act. These monies are not considered in determining appropriations for Indian health care and shall be paid for eligible services regardless of location. Outpatient facilities are eligible if they collaborate with a hospital or other inpatient facility.

Yet at the same time, it is important to recall that health care for tribal members is ultimately a trust responsibility. In keeping with this, the Nation objects to the language added to the proposed section 408(f), which provides an exception and would under certain circumstances allow IHS to bill Tribes for services provided to members. While it is understandable that IHS may need money, it is inconsistent with the federal trust responsibility to bill the beneficiary for services.

In subsection (h) "tribal" should be added to "Federal or State law" as neither state law, nor state court may have jurisdiction over a claim an individual may bring against an insurer for services provided at an on-reservation facility.

Section 410(b) allows recovery from managed care plans for services, for the same reasoning noted above opposing the additional language in 408(f), the Nation proposes that tribally self-funded managed care plans be excluded from the sources of recovery.

Tuba City Demonstration Project - Section 412

Specific to the Navajo Reservation is Section 412, which addresses the Tuba City Demonstration Project. Under this section, the I.H.S. will act as a Medicaid managed care organization in Arizona for people who use the Tuba City service unit. I.H.S will provide Medicaid services in return for a uniform per capita payment from the State of Arizona.

Of course the provisions in the proposed legislation relating to the development of the Navajo Nation "Tri-State Medicaid Agency" are particularly important to the Navajo Nation. This provision would provide the authorization for the Health Care Financing Administration to work with the Nation to provide a uniform rate for medicaid reimbursement eligible services. Currently on the Navajo Nation there are three sets of rules with respect to medicaid reimbursable services - one for each of the states. Having one set of procedures should improve the processing of reimbursements. Additionally, since the Navajo Nation will operate this Medicaid system, we anticipate that the services can be more culturally relevant to the Navajo population.

While the language as proposed sets up this opportunity, upon further reflection some minonr revisions to the proposed language will enhance the ability of the Navajo Nation, and perhaps eventually other Tribe to be more self-determining in this critical area: Section 401(d) as drafted, creates the Qualified Indian Health Program (a new Sec. 1880A), in subsection (c)(5) of the proposed sec. 1880A the full cost recovery rate is to be determined by "the Health Care Financing Administration or by a State Medicaid agency..." To allow for the development of the Navajo Nation Medicare Agency, this language should be changed to read: "the Health Care Financing Administration or by a Medicaid agency recognized by the Health Care Financing Administration..."

Similarly under section (d)(4) there is a reference to a "State Medicaid plan," this should be changed to "operative Medicaid plan" or other such similar language to allow for the development of tribal Medicaid plans.

Section 402(c) amends sec. 1911, which makes substantial reference to "state plans" unless a "catch all" provision is included in the Navajo Nation Medicaid demonstration project section, this should also reference "tribal plans."

Section 404(c) adds language to allow IHS to enter into agreements with a state to facilitate eligibility determinations for M&M recoveries. Given that some states have eligibility determinations made at county or local levels, it would seem appropriate to insert "county and local governments" after "State." On a similar level, this whole section seems unfortunately complex. Under subsection (a) IHS can enter into funding agreements with tribes and tribal organizations for eligibility determinations and enrollment in a state plan. In practice on the Arizona portion of the Navajo Nation, what happens is that IHS gives the Nation these funds, and the Nation then contracts with the county governments for the counties to hire eligibility workers, since otherwise, the Office of General Counsel for IHS has determined that an Intergovernmental Personnel Agreement is required. While this arrangement works, it seems unnecessarily cumbersome; subsection (c) may help address this if "including funding agreements" is inserted after "agreements" in the added language. Otherwise the contracting authority in subsection (a) could be expanded.

Section 405(b)(1) provides that a '638 contractor reimbursed for M&M or CHIP services. Further, "Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used to provide additional health services or improvements in its health care facilities." This statement may conflict with the sections in '638 regarding the use of program income, which can be used to provide additional services under the contract scope of work. While in most cases there will be no conflict - the "additional health services" would be consistent with any given scope of work, it is possible that there might be an inconsistency. Add "consistent with the Indian tribe or tribal organization's contract pursuant to the Indian Self-Determination and Education Assistance Act" at the end of the sentence.

Funding of Unmet Needs and Level of Need Funding

Native American communities have never had their healthcare needs fully met. The Indian Health Service Level of Need Funded resource allocation methodology has outlined a more effective way to address Indian healthcare needs on a national basis. This methodology should be used to address unmet healthcare needs in the Native American/Alaska Native communities. According to the LNF study, I H S is serving only 1.24 million of a total 2.4 million population of Native Americans. The cost is about $2 billion annually. The Navajo Nation is in support of the recommended $7.4 billion yearly budget for adequately serving the Native American/Alaska Native population. This $2,980 per person per year is still beneath the federal and or state healthcare spending levels for non-Indians.

National Bipartisan Commission on Indian Health Care Entitlement

The Navajo Nation is in support of the new provision under Title VIII to establish a 25-member National Bipartisan Commission on Indian Health Care Entitlement to study the provision of health care to Native Americans and Alaska Natives as an entitlement. The Navajo Nation recognizes the unique relationship between Native peoples and the United States government and the federal government's admitted responsibility to Native health care. The Navajo Nation supports this Title as a mechanism to improve delivery of services to Native Americans.

Expansion of Diabetes Prevention and Treatment Program

Diabetes continues to ravage Indian communities. Type 2 or Adult Onset Diabetes is of particular concern as it is affecting Indians in greater numbers at lower age groups. Estimates from I H S and the CDC suggest that an average of 45% of the total Native American community is affected by diabetes. Diabetes is listed as the fifth cause of death among Navajos. Navajos die from diabetes at a rate two thirds higher than the national average. A section under Title II has been revised to eliminate a specific list of model diabetes projects and

move toward establishing more comprehensive diabetes prevention and treatment programs. The Navajo Nation is in full support of expanding the diabetes program with funding.

Inpatient Rehabilitative Therapy

While covering outpatient rehabilitative therapy, I H S does not pay for inpatient rehabilitation. This is often problematic since according to medical professionals interviewed at rehabilitative facilities that are frequented by Native patients, the inability of Indians to enter into inpatient rehabilitative therapeutic situations places them at higher risk for re-injury and slows the pace at which they ultimately recover. Outpatient rehabilitative therapy for patients who have experienced strokes, cranial injury or spinal cord injuries often includes long drives to and from facilities and inconsistent care often resulting in impeded recoveries and re-injuries. Ultimately, the expenses incurred in these situations are higher than the inpatient therapy. The Navajo Nation strongly urges the inclusion of inpatient rehabilitative therapy and other therapies recommended by attending physicians or other health care providers under I H S benefits.

Cultural Issues

Staff at most health care facilities that treat large numbers of Indians rarely speak the Native language or have a clear understanding of the cultures they are serving. The presence of a tribal member familiar with the language and customs of his/her constituency is vital to the quality of Indian healthcare, especially in situations where large numbers of elderly frequent the facility.

The Navajo Nation supports partnerships with I H S facilities or private health care organizations in maintaining staff who speak the dominant Native language and are trained to assist in the delivery of services such as therapies, patient care, nutritional consultation, tests along with cultural and religious consultation to other staff members, networking with Indian communities.

Conclusion

In closing, I thank you for your consideration and urge your continued support for the reauthorization of P.L. 94-437, the Indian Health Care Improvement Act. Of course if the Committee requires further information or assistance with respect to any of the suggestions put forth by the Navajo Nation, we stand ready to work with the Committee.

THE NAVAJO NATION

Kelsey A. Begaye, *President* **Taylor McKenzie, M.D.,** *Vice-President*

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June 19, 2000

Honorable Ben Nighthorse Campbell
Chairman
UNITED STATES SENATE
Committee on Indian Affairs
Washington, DC 20510-6450

Dear Senator Campbell

Thank you for your letter of May 24, 2000 posing several questions in regard to the Reauthorization of the Indian Health Care Improvement Act in follow-up to the May 10th hearing.

I trust the information provided in response will be of considerable help. Thank you for the opportunity to testify on behalf of the "Reauthorization of the Indian Health Care Improvement Act".

Sincerely,
THE NAVAJO NATION

Taylor McKenzie, MD, Vice President

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ATTACHMENT

Response to the four questions raised in
Senator Ben Nighthorse Campbell's
letter dated May 24, 2000

1. **You mentioned in your testimony that the changes to the scholarship provisions will attract more federally recognized American Indian and more "committed" individuals. How?**

The provisions would allow tribes control over their scholarship resources. This responsibility and ownership would allow tribes to administer their own scholarship programs for their tribal members. Tribes know their tribal members and understand the needs and priorities for their tribes in relation to health care needs/issues; therefore they would be in better position to establish scholarship programs that would truly reflect and meet their needs. They can institute screening mechanisms for the selection for qualified tribal members based upon their priorities and eligibility requirements. Tribal members selected directly from their own communities are more likely to return to their people to practice. Such tribal members who are scholarship recipients grew up in the local tribal communities, they know the expectations of their communities, they are aware of the issues/concerns and needs of their communities, they are in a better position to initiate positive changes in their communities, they are in a better position to initiate positive changes in their communities, they have the tribal-family support, etc. Tribes can focus on their "selectees" and put in the effort to provide moral and financial support to see these scholarship recipients through. Through having a voice in their scholarship resources, tribes are in fact committing to their young people to get them through school. Tribes can groom their young people to meet eligibility requirements set by the tribes. Tribes can set expectation for higher education and the rewards that come with it if you succeed.

2. **Please explain to me how the designation of the State of Arizona contract health service area benefits tribes. What would happen if Arizona were not a contract health service area?**

See attached information on Contract Service Delivery Area (CHSDA).

3. **How many Navajo live off the reservation in urban areas? Which urban areas have high numbers of Navajos living in them?**

According to the 1995 Navajo Nation Profile, which is based on the 1990 census, the estimated number of Navajo population in the United States (in 1995) was 259,556. The estimated number of Navajo persons residing off-reservation was 100,075. Excerpts of the 1990 census report is attached.

4. **Your plan to designate dates for completion of tribal facilities contraction for specific projects was interesting. Can you explain how that would work in more detail and how this would benefit tribes?**

Currently, there is nothing in Section 301 (c) that stipulates a time period in which Indian healthcare needs will be met with the goal or ensuring that all communities in need will have facilities built and in operation by a specified date. The designation of dates for completion of tribal facilities construction will allow communities to project patient numbers, staffing needs, etc.

QUESTION: **Explain How The Designation of the State of Arizona Contract Health Service Area Benefits Tribes. What would Happen If Arizona Wer Not A Contract Health Service Area?**

PROPOSED - Generally, the contiguous counties in the State of Arizona are defined by the IHS as a Contract Health Service Delivery Area (CHSDA), namely Navajo Area, Phoenix Area, and Tucson Area. To be eligible for CHS, any beneficiary residing with the CHSDA, but not on the reservation, must be a member of the tribe or tribes for which the reservation was established or "maintain close economic and social ties" with the tribe or tribes. Under the current rule, if a member of a different tribe moves to a CHSDA but does not reside on the reservation, he/she is eligible for direct care but not for CHS care unless he/she has close economic and social ties to the tribe for which his/her reservation was established.

It is not uncommon for tribal members to live near a reservation but in a county that is not contiguous with the reservation (i.e. outside the CHSDA). As long as an Indian beneficiary is a member of a Federally-recognized tribe and resides in a CHSDA, the Indian beneficiary is eligible for CHS care and direct care. If an Indian beneficiary moves near or on another Indian reservation, within the State of Arizona, he/she will not lose eligibility for CHS. The close and social ties test will be eliminated.

In addition, Tribes have mechanism for requesting a redesignation of a CHSDA---any Indian tribal government may request a change in the boundaries of the CHSDA. Further, the IHS many designate States such as counties or towns, or other identifiable geographic areas as CHSDAs where reservations are inappropriate as the basis for defining a CHSDA. Consideration to include: number of persons residing off-reservation who would be eligible for IHS services; number of persons residing off-reservation who have traditionally received IHS health care services but whose eligibility would be affected; the geographic proximity of the off-reservation area to a reservation; and whether IHS beneficiaries residing off-reservation can be expected to need and to use health services provided by the IHS. Given this information, the IHS Director, or his designee, makes the final decision on the tribe's request.

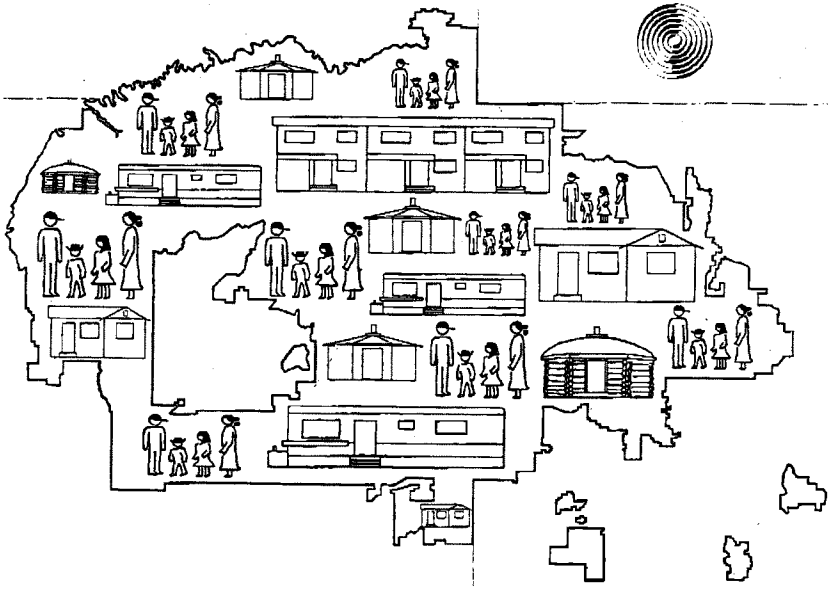
CURRENT - The CFR, Title 42, Section 36.32 (1986) stated that CHS will be made available to otherwise eligible federally recognized Indians who do not reside on a reservation, if they reside within a CHSDA, and (1) they are members of the tribe(s) located on the nearby reservation or of the tribe(s) for which the reservation was established or (2) if they maintain close social and economic ties with than/those tribe(s). A CHSDA is defined as any county that contains all or any part of a reservation or that shares a common boundary with a reservation unless specified by Congress. The regulation also states that, except for transients (migrant workers, travelers, etc.), foster children, and full-time students in institution or higher learning or in Indian boarding schools, federally recognized Indians who leave the CHSDA in which they have CHS eligibility will remain eligible for CHS for a period not to exceed 180 days.

25 U.S.C. 1678 (b) makes it clear that the IHS may not implement Section 1678 (a) by taking funds from services provided to Indian living on reservations. The Senate Report (Senate Report 96-758, at 26 [1980]) accompanying that bill stated that the Committee language assures that reservation health care services will not be diminished because of the designation of Arizona as a single CHS delivery area. The Conference Report (H.R.

Conf. REP 96-1483, at 14, 15 [1980]) accompanying the legislation further stated that no funds were to be made available to implement this section unless specifically appropriated. According to H.R. Rep. 102-643 (I) at 447, 448 (1992), Congress estimated that it would cost $65 million in FY 97 to fully fund the provision to cover all eligible Indians. Consequently, until Congress specifically appropriates funds for section 1678 (a), the IHS is unable to implement the section that states: "that the State of Arizona shall be designated as a CHSDA for the purposes of providing CHS".

1990 CENSUS

CENSUS '90



POPULATION and HOUSING CHARACTERISTICS of the NAVAJO NATION

1-7

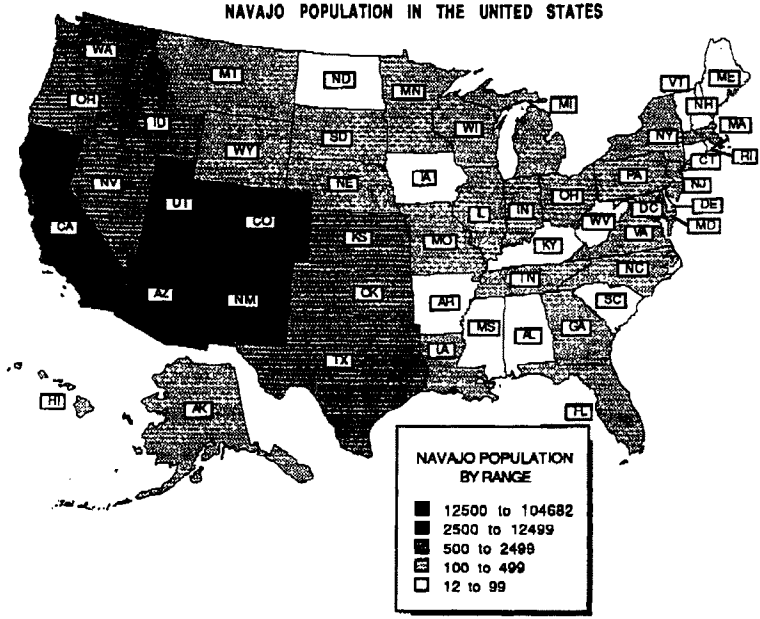
Table US05: TOTAL AMERICAN INDIAN AND NAVAJO POPULATIONS BY STATE AND REGION: 1990

	TTL AM IND POP	NAVAJO POP	PERCENT NAVAJO
UNITED STATES	1,878,285	219,198	11.67
REGIONS/DIVISIONS			
Northeast	121,551	946	0.78
New England	31,986	289	0.90
Middle atlantic	89,565	657	0.73
Midwest	333,998	2,448	0.73
East North Central	147,399	1,178	0.80
West North Central	186,599	1,270	0.68
South	557,214	4,420	0.79
South Atlantic	169,554	1,489	0.88
East South Central	40,220	306	0.76
West South Central	347,440	2,625	0.76
West	865,522	211,384	24.42
Mountain	478,391	201,174	42.05
Pacific	387,131	10,210	2.64
STATES			
New England			
Maine	5,945	30	0.50
New Hampshire	2,075	22	1.06
Vermont	1,650	12	0.73
Massachusetts	11,857	136	1.15
Rhode Island	3,987	25	0.63
Connecticut	6,472	64	0.99
Middle Atlantic			
New York	60,855	273	0.45
New Jersey	14,500	172	1.19
Pennsylavania	14,210	212	1.49
East North Central			
Ohio	19,859	275	1.38
Indiana	12,453	139	1.12
Illinois	20,970	394	1.88
Michigan	55,131	254	0.46
Wisconsin	38,986	116	0.30
West North Central			
Minnesota	49,392	145	0.29
Iowa	7,217	55	0.76
Missouri	19,508	228	1.17
North Dakota	25,870	53	0.20
South Dakota	50,501	151	0.30
Nebraska	12,344	112	0.91
Kansas	21,767	528	2.42

	TTL AM IND POP	NAVAJO POP	PERCENT NAVAJO
STATES (Continued)			
South Atlantic			
Delaware	1,982	18	0.91
Maryland	12,601	221	1.75
District of Columbus	1,432	18	1.26
Virginia	14,893	266	1.79
West Virginia	2,385	36	1.51
North Carolina	79,825	276	0.35
South Carolina	8,049	82	1.02
Georgia	12,926	188	1.45
Florida	35,461	384	1.08
East South Central			
Kentucky	5,614	85	1.51
Tennessee	9,859	100	1.01
Alabama	16,312	72	0.44
Mississippi	8,435	49	0.58
West South Central			
Arkansas	12,641	88	0.70
Louisiana	18,361	101	0.55
Oklahoma	252,089	924	0.37
Texas	64,349	1,512	2.35
Mountain			
Montana	47,524	335	0.70
Idaho	13,594	715	5.26
Wyoming	9,426	244	2.59
Colorado	27,271	3,604	13.22
New Mexico	134,097	77,927	58.11
Arizona	203,009	104,682	51.57
Utah	24,093	12,861	53.38
Nevada	19,377	808	4.16
Pacific			
Washington	77,627	774	1.00
Oregon	37,443	617	1.65
California	236,078	8,538	3.62
Alaska	31,245	138	0.44
Hawaii	4,738	143	3.02

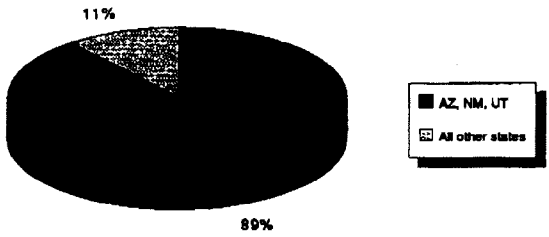
SOURCE: 1990 Census; CPH-L-99; Extracted by DCD

NAVAJO POPULATION IN THE UNITED STATES



Arizona, New Mexico, and Utah have a combined Navajo population of 195,470 - representing 89% of all Navajos in the United States. The top ten states, in order of rank, are: Arizona, New Mexico, Utah, California, Colorado, Texas, Oklahoma, Neveda, Washington, and Idaho. These make up a total Navajo population of 212,343 or 96.9% of all USA Navajos.

Navajo Population by Three-State Area and Remainder of U.S.



SOURCE: 1990 Census; Graphics by DCD

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Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
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Warm Springs Tribe
Yakama Nation

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SENATE INDIAN AFFAIRS COMMITTEE HEARING ON LEGISLATION TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

Wednesday, May 10, 2000

9:30 a.m.
485 Russell Senate Office Bldg.

Julia A. Davis,
Nez Perce Tribe Executive Council
Northwest Portland Area Indian Health Board
National Steering Committee on the Reauthorization
of the Indian Health Care Improvement Act

Testimony May 10, 2000
Senate Indian Affairs Committee

Co-chairs Campbell and Inouye, thank you for inviting me to testify today on the Indian Health Care Improvement Act. I am Julia Davis, recently reelected member of the Nez Perce Tribe's Executive Council. I am also Vice Chair of the National Indian Health Board and Chair of the Northwest Portland Area Indian Health Board. Thank you for this opportunity to testify on behalf of the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. The NSC Committee appointed a Reauthorization Leadership Group and I am one of its six members. Today I would like to review Title III, the facilities section of the draft bill on the Reauthorization of the Indian Health Care Improvement Act (PL 94-437).

As others will mention today the draft bill is the Senate version of the consensus bill developed by tribes last May through October in what was a good example or perhaps model is a better word of a good consultation process. This bill was developed by tribes and urban Indian groups and reviewed and commented on by American Indians and Alaska Natives nationwide.

I was the co-chair of the Facilities workgroup within the National Steering Committee. I was pleased with the cooperative spirit that attended the developed of Title III. I want to acknowledge the hard work of those who contributed to this section of the bill including my co-chair Robert Nakai of the Albuquerque Area. Tribes donated valuable staff time and the Indian Health Service provided additional technical support. I think it is a strong section that if passed as proposed would vastly improve the sorry condition of the facilities infrastructure of Indian health programs.

Before I review the bill I would like to say just a few words about federal funding for health facilities. Medicare and Medicaid provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare or Medicaid program. Yet American seniors receive care in the most modern clinics and hospitals in the world. Indeed it is remarkable, but true, that poor Americans who are eligible for Medicaid in Washington, Oregon, and Idaho now receive their care in the same facilities as other non-poor Americans, that's right, in the very same clinics and hospitals that are the envy of the world.

What about Indian people? Their clinics, with notable exceptions are old. on average more than 30 years old. My clinic in Lapwai, Idaho is over 40 years old. The Clinic director has her office in a windowless basement room. Many of our clinics are mobile homes really. Often, when one of our tribal members becomes eligible for Medicaid they choose to drive 20 miles to Lewiston to see a doctor in a modern facility, not in our Nee Mee Poo clinic.

The clinics are not just old. They are inadequate. They are too small, the equipment is often outdated, and the staff is forced to make do as best they can. That is, the staff that is willing to stay under these less than desirable conditions. My tribe just lost a native doctor to an urban clinic. Who can blame someone for not wanting to work up to their potential in a modern facility with start of the art equipment?

What explains the poor condition of so many Indian clinics?

Unfortunately, it is the budget process itself that annually underfunds the Indian Health Service budget that is the cause of the poor condition of our facilities. There is no doubt that again this year little progress will be made to address our backlog of facilities need. As a discretionary program the Congress will ask tribes the annual question: Do you want this year's proposed $229 million increase to go to health services programs or facilities? This choice is unfair. No one asks Medicare recipients if they want facilities or programs---they get both. The health plans that deliver care to Medicaid and Medicare patients take out a portion of each dollar paid by these programs to provide adequate facilities. It is bad health care and bad business to have poor facilities. The idea of slicing off a portion of our inadequate health services dollars for facilities is not realistic. There is nothing to slice. Because the Indian Health Service is a discretionary program our funding is limited and proposals for facilities construction are the low hanging fruit that is chopped off every year. In fact, I think it is wrong that we don't ask for more than we do each year.

What is new in Title III of the draft bill?

Our general goal was to grant authority to tribes and the Indian Health Service to meet our need. I have little hope that these authorities will produce the funding needed to meet that need, however. We reaffirmed our support for existing alternative financing mechanisms like joint venture and

proposed new ones like a revolving loan fund to finance facilities construction. In the Northwest, we believe innovative financing of facilities will reduce that gap between our current facilities and our need.

The new title requires the Secretary to develop a new priority system for construction through negotiated rulemaking with tribes, tribal organizations and urban Indian organizations. The consensus bill does include a provision that recognizes that many tribes have waited a long time under the existing system and states that the existing priority list will be used for projects in phase 1 and 2 of construction. An annual report would be required of the need for new facilities; inpatient, outpatient and specialized care facilities. Northwest tribes have expressed the desire that this report take a close look at the need for new inpatient facilities as opposed to alternatives such as clinic construction and expanded contract health dollars to meet the need.

The Sanitation section also tries to promote aggressive cooperation between agencies to maximize revenues to meet the need. It also encourages closer cooperation between the Indian Health Service and tribes to understand and meet sanitation needs. It gives the Indian Health Service the authority to enter into inter-agency agreements with State and Federal agencies to maximize funding opportunities.

For Maintenance and Improvement the new act requires a report to the Congress and President on the backlog of maintenance as well as the expansion and renovation needs of health program facilities. The new section also allows M & I funds to be used to build new facilities if the cost is less than 80 % of what would be spent on repairs.

The staff quarters section allows tribes to set the rental rates for the quarters and authorizes tribes to directly collect rents from federal employees.

I think the proposed Title III section has widespread support. In the Northwest we have presented the title to our Board and at two special meetings, one on December 15, 1999 and at another meeting of direct service tribes on April 14, 2000. I can report to you that our tribes have not expressed any serious reservations about Title III, however I would understand if some tribes would like to have more time to fully understand this section of the bill. Thank you and I would be happy to answer any of your questions.

Julia Davis, Chair Northwest Portland Area Indian Health Board

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Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
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July 18, 2000

Honorable Ben Nighthorse Campbell
Senate Committee on Indian Affairs
838 Hart Building
Washington, DC 20510

Dear Chairman Campbell,

Thank you for your letter of May 24, 2000 and your questions regarding the October 6, 1999 draft bill for the reauthorization of the Indian Health Care Improvement Act. I would like to respond to your questions from the perspective of both the National Steering Committee and the member tribes of the Northwest Portland Area Indian Health Board.

Your first question concerns the definition of Indian contained in the draft bill.

Definition of Indian

I do not believe there was a conscious choice to reduce the number of Indian people who are eligible for services from the Indian Health Service. You are correct in noting that the definition used in the National Steering Committee draft would be more restrictive than the current practice of requiring only Indian descent for the use of direct service provided by Indian health programs. The proposed bills (HR 3397, S. 2526, and the N.S.C. draft) all cite the P. L. 93-638 definition of Indian as meaning someone who is a member of a federally recognized tribe. I frankly do not recall any discussion of adopting this definition as a way to reduce the number of eligibles. I do know there was a desire to emphasize that the trust responsibility for health care is between tribes and the federal government and the P.L. 93-638 definition emphasizes the government-to-government relationship. Your observation, however, is also true. It does allow an interpretation that would restrict eligibility.

The second N.S. C. draft of the act contained the following definition comparable to current law and this was changed in the forth and the fifth (final) version of the proposed National Steering Committee bill.

> (c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of section 102 and 103, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the

Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

With the exception of authorizing services to 'state-recognized' tribes the National Steering Committee had no real problem with the current law definition. I know the National Steering Committee would not support the definition to include state-recognized tribal membership making someone eligible for services of the Indian Health Service.

There was certainly no intention to restrict the eligibility of urban Indians. In fact, the National Steering Committee agreed to add a separate definition to reflect their historical circumstances.

I think the draft definition does not cover the desired categories of persons that are covered under current law and the National Steering Committee will offer a recommended amendment to be sure we do not make the definition too restrictive.

There are two other provisions in the act that deal with the issue of eligibility and the definition of Indian. One is section 811 that would require negotiated rulemaking to set eligibility criteria. Another is section 816 that establishes a national Bi-Partisan Commission on Indian Health Care Entitlement that would have one of its charges be a review of the definition of Indian and eligibility.

In response to question 2 regarding dialysis machines, I do remember discussions about the need, but I also remember questions being raised about whether or not authorizing language was needed for such a narrowly defined service. The feeling was that because of barriers to access due to remote location and high cost the new act should highlight the need for dialysis with a specific authorization. Again, the National Steering Committee may want to revisit this issue and I will recommend that they do so.

In response to question three, there are several new and expanded provisions that will create new opportunities to meet our facilities needs.

Title III Construction Opportunities

Many provisions of Title III offer alternative means for tribes and tribal organizations served by IHS-funded health programs to finance construction and renovation of health care facilities. They may be used independently of each other or in combination to build facilities outside the present IHS Construction Priority System and address the critical health care facility needs in Indian country. The primary new construction financing provisions are:

Section 305 is modified to authorize the IHS to accept expansions of existing facilities financed by sources other than IHS.

Section 306 strengthens the existing, but not funded, program for grants to construct and renovate small ambulatory care facilities in the hope that this section more likely will be funded.

Section 307 authorizes contracts, grants and loans for testing alternative means of constructing or renovating Indian health facilities including projects which combine IHS funds with other federal or non-federal funds.

Section 309 strengthens the existing statute which encourages the use of lease assignments (the tribe leases the facility to IHS and utilizes an assignment of lease rentals to amortize construction financing) by requiring that such leases be treated as "operating leases" under the Budget Enforcement Act. This would allow the lease costs to be scored over the term of the construction loan rather than all in the first year as is now the case.

Section 310 establishes a program of federal loans, loan guarantees, and grants for loan repayments to provide a new source of financial assistance for health facility construction. The Health Facilities Loan Fund under section 310 is described below.

Section 311 is expanded to allow tribal organizations (which are frequently health care providers under the ISDEAA) to lease facilities for health care services without advance approval in appropriations legislation. At present this authority is limited to tribes.

Section 312 expands an existing demonstration project to allow tribal organizations, as well as tribes, to enter into a joint venture with IHS under with the tribe or tribal organization provides the facility at no cost to IHS and IHS agrees to fund the services.

Section 317 authorizes IHS to accept funds from any sources, including federal and state agencies, for health facility construction and renovation and to enter into agreements with other federal agencies, state agencies, and other entities. Federal agencies are authorized to transfer funds for construction to the IHS.

Each of these provisions provides an additional alternative means of reducing the enormous backlog of health facility construction needs in Indian and Alaska Native communities. Perhaps the most valuable feature of these provisions is that they may be used in combination to create a viable financial package. A facility could be funded partly from a tribal loan from HHS, partly from a federally guaranteed private loan and (for tribes able to afford it) partly from a contribution of tribal funds. The facility could be leased in advance to IHS and the construction financing could be paid off from lease rentals.

IHS can presently document an Indian health facility construction need of over $1,000,000,000 and estimates a long-range requirement of over $3,000,000,000. Section 301 would require IHS to annually update the total Indian health facility construction need. At the present rate of construction with appropriated funds under the Indian Health Construction Priority System it will be many generations before Indian health care is provided throughout the United States in safe and reasonably adequate facilities. The absence of such facilities is dramatically in contrast to the goals of the Indian Health Care Improvement Act.

In response to question 4 regarding the revolving loan fund, I am please to report on this new mechanism that Northwest tribes have promoted over the past four years.

HEALTH FACILITY LOAN FUND

You have requested an explanation of the Health Care Facility Loan Fund, a new revolving fund which would be established under section 310 of the bill. The loan fund is intended to provide a source of facility funding for Indian and Alaska Native tribes which have no prospect of prompt construction under the Priority System and which lack adequate revenue or resources to provide tribal funding or borrow in the private sector for the total cost of needed health facility construction or renovation.

The details of how the fund would be administered would be provided in regulations developed by the Secretary with tribal involvement through negotiated rulemaking and subject to standards specified in section 310(b).

In some instances a financial package including a federal loan, a federal guarantee of a bank loan, together with lease rentals from a lease to IHS, will be a viable means of meeting with need without adding to the direct appropriations for construction. These methods would also permit the introduction of innovative design methodologies which IHS has hitherto resisted. While facilities should meet Joint Commission for the Accreditation of Health Organizations and Uniform Building Code Standards, cost could be reduced by avoiding more rigid standards imposed in IHS planning.

The larger the revolving fund the more it would be able to contribute to the reduction in the facility backlog, presently documented by IHS at over $1,000,000,000. We recommend a $100,000,000 revolving fund as a start, but even as little as $25,000,000 would provide a useful additional alternative for assisting in meeting the need.

In response to part A of question 4 regarding the award of scholarships to non-Indians, I know that the National Steering Committee agrees with you that the

purpose of this title is train American Indian and Alaska Native providers. We need to do all we can to make sure our recommended language accomplishes this goal. I have asked the National Steering Committee to take another look at the provisions in Title 1 of the proposed act.

Your related question in (B) about Indian Health Service policy favoring physicians was also reported to the National Steering Committee. I know that we too were concerned that a policy that favors physicians over other health professionals is not in the best interest of Indian people. I think the National Steering Committee should consider more specific language to accomplish the desired goal.

Thank you for the questions you have raised. I assure you that I have brought all these concerns to the attention of the Reauthorization Leadership Group of the National Steering Committee at a meeting in Albuquerque, New Mexico on July 12, 2000. They have asked me to prepare my response from the perspective of the National Steering Committee as a whole rather than as a response from the Northwest Portland Area Indian Health Board and our member tribes. I have agreed to do so and, in fact, believe that our answers would be no different if only our tribes were consulted.

I will provide you with follow-up to all your questions. Please contact me or Ed Fox, our Northwest Portland Area Indian Health Board staff person working on the Indian Health Care Improvement Act Reauthorization, at 503-228-4185.

Sincerely,

Julia A. Davis

Statement of Yvette Roubideaux MD MPH

President

Association of American Indian Physicians

Before the Senate Committee on Indian Affairs

On the Reauthorization of the Indian Health Care Improvement Act

May 10, 2000

Good Morning, Mr. Chairman and Members of the Committee. My name is Dr. Yvette Roubideaux, and I am the President of the Association of American Indian Physicians. I am a member of the Rosebud Sioux Tribe, and am a Harvard-trained, Board-certified Internist with experience working in the Indian health system. I am currently a Clinical Assistant Professor in both the College of Public Health and College of Medicine at the University of Arizona In Tucson AZ. I am honored and grateful for this opportunity to testify in support of the Reauthorization of the Indian Health Care Improvement Act (P.L. 94-437). On behalf of the Association of American Indian Physicians, I would like to thank you for the opportunity for our organization to provide testimony today.

I am proud and honored to be the President of the Association of American Indian Physicians, which I believe is now beginning to realize its role as a leader in improving the health of Indian communities. The Association of American Indian Physicians (AAIP) is a national non-profit organization located in Oklahoma City that was founded in 1971 by 13 Indian physicians. AAIP now has a diverse membership of approximately 300 American Indian and Alaska Native physicians from all regions of the country with expertise in many areas. The mission of the Association of American Indian Physicians is "to pursue excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing practices and restoring the balance of mind, body, and spirit." While the activities of the Association of American Indian Physicians focused for many years on the recruitment and retention of Indian students in the health professions, now that we have a critical mass of members we are expanding our programs to include more education on Indian health issues, Indian health program development, and education on Indian health policy issues. We now have the capacity to be a significant resource for tribes, Indian communities and other organizations and groups such as the Senate Committee on Indian Affairs. We are grateful for the opportunity to provide input today because many of our members have seen first hand the health problems and challenges in Indian communities, and the pressing need for more resources and efforts in all areas of Indian health.

Despite being trained at the best medical school and residency program in the country, I faced significant sadness and frustration at my inability to provide quality health care to my patients when I worked in the Indian Health Service due to the severe lack of resources, outdated equipment and facilities, and shortages of high quality health care providers and staff. Many of our members struggle to provide quality health care despite these obstacles, but sadly, many also suffer significant symptoms of burn out and decide to leave the Indian health care system. While the Association of American Indian Physicians has approximately 300 members, and approximately 200 of these members have practiced medicine in the Indian health system at one time, only 69 of our members currently work in Indian health system. Currently, a total of 852 full time physicians of all races work in the Indian health system. Many of our members who leave the Indian health system are disappointed about the generally poor working conditions, lack of resources, and lack of recruitment or retention efforts to keep them in the system. While not all Indian physicians who graduate from medical school want to work in Indian health, there should be more efforts to recruit and retain American Indian health professionals with an interest in working in the Indian health system. Sadly, according to 1990 Census data, American Indians are the most under-represented minority in the physician category, with only 48/physicians/100,000 population, compared to other racial categories and the overall total (236 physicians/100,000 population).

We support Reauthorization of the Indian Health Care Improvement Act and its reaffirmation of the federal trust responsibility to provide health care for American Indians and Alaska Natives, and the sovereign rights of tribes to self-determination and self-governance. We support the goal of the United States to raise the health status of Indians to the highest possible level and believe that American Indians and Alaska Natives deserve the highest quality of health care. We also believe that American Indians and Alaska Natives deserve the opportunity to receive medical care from well-trained, culturally competent American Indian and Alaska Native health professionals. The major focus of our testimony today will be on Title I – Indian Health Human Resources and Development.

We are grateful for the Indian Health Service Scholarship program, authorized under the Indian Health Care Improvement Act. I would not be sitting here today as a physician without the support that I received under Sections 103 and 104 of Public Law 93-437. However, more funding and administrative support is needed for the scholarship program. Under Title I, the various components of the scholarship program have been amended to broaden the scope of health professions covered, allocate resources, decision-making and priority setting to the Areas, and require payback of scholarship obligations within the Area from which the scholarship was awarded. While we agree that the scholarship program should be more responsive to local priorities and needs, and are supportive of more local participation, we are not supportive of further

restrictions on the location of the payback obligations for these scholarship recipients. Placing more restrictions on the placement of Indian health professionals for their payback positions will further demoralize them, worsen efforts at recruitment and retention, and potentially result in placement of health professionals in facilities or positions that do not match their qualifications or career needs. Currently, scholarship recipients are allowed to payback their obligations in areas where there are shortages of staff or on their own reservations. We strongly recommend that the current rules should be retained and that language that restricts payback to the specific Area from which the scholarship is received should be changed. The language that says "...for special circumstances a recipient may be placed in a different Service Area..." is not strong enough and does not guarantee appropriate placement for these recipients. We also believe that scholarship recipients should be eligible for the Loan Repayment Program and any available recruitment and retention bonuses. We also agree with clarifying that scholarships and repayment of loans are "non-taxable," and to ensure culturally competent care, we support the requirement for training new health professionals in the culture and history of the tribes they will serve.

While most of our comments today were limited to Title I of the Indian Health Care Improvement Act, we also would like to briefly comment on the other Titles in the Act. In Title II, Section 204, we support continued funding of the current model diabetes programs and programs funded under the Special Grants for Diabetes Program created under the Balanced Budget Act of 1997. Funding for these programs must be continued through 2012 as the problem of diabetes in American Indian communities is reaching epidemic proportions and more resources and programs are needed to fight this growing problem. In addition, we support retaining language to fund at least one Area Diabetes Consultant (formerly known as diabetes control officers) for each Service Area and disagree with current language to retain these positions at the discretion of each Area. We also support expansion of screening for all cancers in Section 207, and funding of tribal epidemiology centers in all Areas as stated in Section 209.

We support all provisions in Title III that would allow the construction of high quality state of the art health care facilities for all Indian communities as soon as possible. In Title IV, we support maximizing reimbursement for services from all third party sources, and we support protecting the opportunity of Indian people to receive health care in culturally competent Indian health programs rather than being assigned to unfamilar, distant managed care organizations. In Title V, we support the recommendations and changes for Urban Indian programs, primarily because these programs are severely under-funded despite being the primary source of health care for a large proportion of the American Indian and Alaska Native population. While we recognize and respect the government-to-government relationship of the tribes with the federal government, we also support finding mechanisms to help fund and support Urban Indian programs to address the health needs of tribal members in urban areas.

We strongly agree with the recommendation in Title VI that the Director of the Indian Health Service be elevated to an Assistant Secretary for Indian Health and that this be incorporated into the Indian Health Care Improvement Act if similar legislation is not passed. We also strongly recommend that the position of the Director of the Indian Health Service should continue to be filled by an American Indian or Alaska Native physician. In Title VII, we support the recommendations for behavioral health and increased funding and support in this area. In Title VIII, we are supportive of the establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement to examine the establishment of an entitlement provision for Indian health services. We would like to recommend that a representative from the Association of American Indian Physicians be appointed to serve on this Commission, as our members are knowledgeable about health care services for Indians and can serve as a resource for this Commission.

On behalf of the Association of American Indian Physicians, I would again like to thank the Senate Committee on Indian Affairs for the opportunity to provide testimony at today's hearing on the Reauthorization of the Indian Health Care Improvement Act. Our organization is available as a resource to your Committee and the tribes and Indian organizations involved in this process, and I encourage you to call upon us again for any assistance. We are grateful for the opportunity to support the Reauthorization of the Indian Health Care Improvement Act, and encourage your efforts to help achieve reauthorization as soon as possible. Thank you.

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June 16, 2000

Ben Nighthorse Campbell, Chairman
United States Senate Committee on Indian Affairs
Washington DC 20510-6450

Mr. Chairman,

I am writing to answer your follow-up questions in response to my testimony at the May 10th hearing on the Reauthorization of the Indian Health Care Improvement Act. I am grateful for the opportunity to respond and to help clarify these issues in writing, and thank you for allowing the Association of American Indian Physicians to provide input on this important legislation. My answers to each question are as follows:

1. What can we do to attract more American Indians and Alaska Natives into health professions?

I believe it is possible to attract more American Indians and Alaska Natives (AIAN) into the health professions through 3 strategies:

1) creating opportunities for young students to see that other AIANs have successfully entered the health professions (role modeling)
2) developing more opportunities for students interested in the health professions to learn how to successfully prepare for these careers (mentoring)
3) identify more resources to financially assist students as they pursue careers in the health professions (scholarships/loans)

In terms of the first strategy, AIAN students often do not consider health professions because they cannot picture themselves in this role due to a lack of AIAN role models. With the shortages of AIAN in the health professions, students often do not get the chance to see many AIAN health professionals, and therefore do not realize that they could enter these careers. Students also need to see these role models early in life in order to influence their future career choices and to help focus their studies in science and math. For example, the Association of American Indian Physician conducts a summer program every year called the "National Native American Youth Initiative" in which 50 high school juniors and seniors are introduced to the health professions by AIAN

physician role models. More funding is needed for programs for young students to help them see AIAN role models who serve as evidence that they can choose to enter the health professions.

With regard to the second strategy, AIAN students interested in health careers need to learn the steps they must follow to successfully enter the health professions. Because there is a lack of AIAN role models, students often have difficulty finding health professionals who can mentor them and help assist them during their training. Often AIAN students are at a disadvantage compared to other students whose mothers or fathers are health professionals and who can help their children learn the steps to enter these careers. Many AIAN students are the first individuals in their family to attempt to have a career in the health professions, or even are the first person in their family to go to college. Workshops and training sessions are needed for AIAN students to help them learn what steps they need to take to successfully enter the health professions. For example, the Association of American Indian Physicians conducts a number of "Pre-Admission Workshops" for AIAN students who are in their pre-med courses to help them learn how to successfully apply to medical school, write their application essays, and prepare for their interviews. During these workshops, AIAN physicians talk with the students about their experiences and give advice on how to overcome barriers.

The third strategy addresses the issue of the high cost of health professional education and the difficulty that AIAN students have in finding ways to pay for medical school or health professional training. Since over a third of AIAN live under the poverty level, many families can barely afford to live and cannot contribute to helping their children attend college or training. In addition, financial aid programs at colleges routinely expect significant family financial contributions, which many AIAN families cannot meet. The Indian Health Service Scholarship program has helped many students enter the health professions who otherwise would not have been able to afford to go to college or medical school, and has been very successful at increasing the numbers of AIAN health professionals. However, more funding is needed, as each year there are many applicants who cannot receive funding due to budget limitations. We recommend that the funding for this program be increased as much as possible, so that more students can have the opportunity to enter the health professions.

2. **Your testimony indicates that the requirement that scholarship recipients serve in the area that funds their scholarship should be removed. Yet rural tribes continuously report a shortage of health professionals. How do we address those needs if we follow your recommendations to remove the requirement that the people who are trained with IHS money serve in the area that funded them?**

Actually, the current scholarship program does not require recipients to pay back in the specific area that funded them since the program is administered

nationally. The NEW language in the draft legislation adds the requirement that students pay back to the specific area that funds them. We are recommending that the current payback requirements are retained and that the new language is NOT adopted.

I must clarify that I think that the Indian Health Service Scholarship Program is a wonderful program that has enabled many AIANs to enter the health professions. The CURRENT payback rules allow AIANs to payback their scholarship obligations in areas of "high need" and they can choose from sites identified by the IHS Scholarship Program. These sites include health programs and facilities around the country that have had problems in filling their vacancies. They are not limited to particular areas of the country in the current program.

In the NEW draft legislation developed through the tribal consultation process, the IHS Scholarship Program was changed to allow more local control of the program. In the new language, much of the administrative functions of the scholarship program are transferred to the IHS Areas, including priority setting, selection of recipients, and control of funding. However, in this new language, the payback requirement was changed from the current practice of allowing students to choose from identified sites around the country to a strict limitation of the payback to the specific area from which the scholarship funding was received. We are opposed to this NEW language that limits payback to one specific Area. We do believe that recipients should payback their obligations in high need areas, but should be allowed to choose from sites in more than one area. Not only does retaining choice in payback sites help with retention, it also ensures that the recipient is matched well to the site so that the highest quality of care can be provided for Indian people. Pediatricians should be allowed to payback their scholarships in sites with positions for pediatricians, and Internal Medicine physicians should be allowed to payback their scholarships in sites with positions for Internal Medicine physicians. Limitations on payback sites in one area only create the possibilities of physicians being forced to payback at sites that do not have appropriate positions for their training, thus jeopardizing the care of Indian people. The scholarship program must RETAIN its current payback system that allows recipients to choose from identified high need sites in all areas, and these choices should not be limited to one area.

So for example, I was a scholarship recipient from the Aberdeen Area. When I was ready to begin my payback, I received a list of "high need" sites in all of the 12 IHS Areas, and was allowed to pick from this list for my payback site. At that time, there were no sites in the Aberdeen Area that were appropriate for my specialty (Internal Medicine), so I picked a site in the Phoenix Area that allowed me to focus on Internal Medicine. I was happy at this site, was able to use my skills, and have remained working in the Indian health field ever since. That particular site was one of the highest need sites in the country, and I helped fill a vacancy that had gone unfilled for several years. The position was appropriate for my skills, so I was able to provide high quality care for the Indian people that I

served. However, if I were forced to payback at a site in Aberdeen, it is likely that I would have had to practice outside of my training which would have significantly put patients at risk, and may have adversely affected my happiness and retention at that site or in the Indian health system in general.

Therefore, while we are supportive of more local control of the scholarship program, we are not supportive of the new requirement that recipients payback only in one area. We believe that the current payback requirements should be continued, and that new language in the legislation that restricts payback to one area be removed. By making the scholarship program more flexible and attractive, we will encourage more students to apply for it and this will increase the pool of health professionals available to work in the highest need sites in the Indian health care system. The best way to attract health professionals to work in areas of high need are to create positive incentives to help recruit and retain them, not to place more restrictions on them and force them to go to places that they do not want to go. I think every IHS scholarship recipient understands that they need to payback their scholarship in an area of high need; retaining the ability to choose which high need site will help ensure the highest quality of health care for AIAN people. Please retain the current payback system, and do not adopt the new language in the draft reauthorization bill.

3. If scholarship funds are not adequate to cover the cost of medical school, what technically prevents scholarship recipients from also receiving loan repayment funds?

The Indian Health Service will not allow an IHS scholarship recipient to receive loan repayment during the time they are repaying their IHS scholarship. They will also not allow AIAN who are in IHS scholarship payback status to receive recruitment and retention bonuses. Their logic is that they are already receiving a bonus, since they are in payback status. However, this system creates a hardship for AIANs since the scholarship funds often do not cover all of the costs of medical school. I had to take out additional loans each year just to survive, as the stipend only covered part of my living expenses. So, while I was in payback status for my IHS scholarship, I also had to use my salary to pay back my loans. The other non-Indian physicians I worked with were eligible for loan repayment, so while we made the same base salary, they got their loans repaid, whereas I has to use my salary to make my loan payments. Many AIAN physicians believe that this restriction creates a "second class" system where the AIAN physicians on payback status actually make less total salary than the non-Indian physicians who are eligible for bonuses and loan repayment. This adversely affects the retention of the AIAN physicians, who become frustrated as they watch their colleagues receive loan repayment and therefore have a higher salary. I believe that the language in the Indian Health Care Improvement Act creates this limitation, and that a simple change in wording could allow AIAN physicians in payback status for the IHS scholarship to be eligible for loan payment and

recruitment/retention bonuses also. We believe that this would help in recruitment and retention efforts enormously for the Indian health system.

4. You have recommended that the position of area diabetes officers, previously required in the act but dropped in this draft, be retained. Why do you think this is important?

Area diabetes officers, or Area diabetes consultants as they are referred to now, have served a critically important function in the Indian health care system since the creation of the Indian Health Service Diabetes Program in the 1970s. Area diabetes officers help coordinate diabetes related activities in each area, and serve as a regional resource for technical assistance for all the programs in the area. In addition, the Area diabetes officers now also serve as project officers for the Special Diabetes Grants for Indians Program created under the Balanced Budget Act of 1997. Their role has never been more important than now as many tribes and Indian health programs have requested more technical assistance as they develop their new diabetes programs with their grant funding. The new language in the draft changes these positions to be at the discretion of the Areas. This creates the possibility that some areas may choose to discontinue this position and allocate funding elsewhere. However, this would be detrimental as it would destroy a critical position in the network of diabetes resources in the Indian health system and local programs would no longer have access to technical assistance, which they have clearly stated that they are in need of during a series of regional meetings held by the Indian Health Service Diabetes Program this year. We recommend that the language that requires Area diabetes officers in each area be retained to ensure that this resource continues to be available to local programs in all areas.

5. Diabetes continues to increase among American Indians and Alaska Natives at an alarming rate. As a medical doctor, what do you think needs to be done to curtail the incidence of diabetes?

Diabetes is a serious, growing problem for AIAN communities. While there were rare case reports of diabetes in the early 20th century, we have entered the 21st century with some AIAN communities experiencing the highest rates of diabetes in the world. This alarming increase of diabetes is due to the dramatic changes in the lifestyles of AIAN, including a more western high fat, high calorie diet and less physical activity, all resulting in alarming rates of obesity. These changes in diet and lifestyle have taken AIANs away from their more healthy traditional lifestyles of the past. AIANs did not have diabetes as a problem 100 years ago because they lived a healthy lifestyle that promoted wellness and prevention. Now, the lifestyles of AIANs have changed in ways that have adversely affected their health.

There have been many advances in the medical research on diabetes, and several studies are now beginning to suggest that diabetes can be prevented in

those at risk for this disease through healthy diet and regular exercise. Therefore, strategies to address the rising rates of diabetes need to focus on helping AIAN communities learn to be healthy again. This includes the need for more education about diabetes, its risk factors, and how to prevent it, as well as education on how to eat healthy and exercise. In some communities, combining this education with lessons from our past traditions can help increase the acceptability of this education to AIANs. In addition, these messages about healthy diet and exercise need to be taught to AIAN people throughout their lives, including education for young children while they are in school.

The Special Diabetes Grants for Indians Program is an example of what we can do to help in the fight against diabetes. As a result of this $150 million grant program, 333 new IHS, tribal, and urban diabetes programs have been created in AIAN communities, and many of them focus on the prevention of diabetes in their communities through education. This grant program has provided funding for prevention and treatment services throughout the Indian health system, and the recent Interim Report to Congress from the Indian Health Service Diabetes Program details the variety of programs that have been implemented. However, based on the series of regional meetings by the IHS Diabetes Program, more funding is needed, especially for technical assistance in program evaluation, data/epidemiology, and program development. The funding for this program should be continued and increased markedly if possible. Doubling or tripling the funding will help but will still not meet the incredible need for prevention and treatment services in the Indian health system.

However, there is still a great need for more research to determine the best strategies to address the problems of diabetes in AIAN communities. While there is plenty of research on what works in the general population, there is little research available in the medical literature on what works in the AIAN population. Actually, much more funding is need to encourage "translation" of current research results into practice in AIAN communities. For example, the diabetes community in the U.S. recently celebrated the findings of the UKPDS study, which finally showed that the complications of diabetes can be prevented through intensive control of blood glucose. However, it is not clear how these findings can be translated into the care of AIANs. For example, in order to achieve the great reductions in complications, intensive education of each patient needs to occur with close follow-up by providers. As you are aware, the Indian health system is faced with a shortage of health care professionals and funding, and it is likely that it will be difficult for Indian health programs to provide the level of care that can reduce complications. More funding is needed for research to determine the best way to implement the findings of this important research as soon as possible to help AIAN with diabetes prevent complications. Another area where more research is needed is the behavioral and mental health effects of diabetes. We enthusiastically support your previous recommendation to establish additional diabetes prevention and research centers in the country to help address the problem of diabetes in AIAN communities.

6. Why do American Indians and Alaska Native suffer so many serious health deficiencies – is it genetic, environmental, or is there a combination of reasons?

A number of factors influence the health of a population, including genetics and a number of environmental factors which include lifestyle and behavioral factors, environmental and toxic exposures, and all of the health effects of poverty and lower socioeconomic status. In addition, the significant disruption of the social capital of AIAN communities with the loss of traditional ways has also disrupted those systems that were in place to promote health and prevent disease. I often teach about public health issues and always try to make the point that AIAN communities had the first primary care, prevention-oriented, public health systems of health care prior to contact by Western civilizations. There are plenty of studies in the public health literature about how the health status of populations and communities depends to a significant extent on how successful their communities are in terms of socioeconomic status and in terms of human capital and social support.

Therefore, the health of AIANs depends on the health of the communities in which they live, and because a number of factors influence health, all efforts to address these factors and help restore wellness, health, economic and politic success to AIAN communities will help improve the health of AIANs. More funding is needed to study these factors and how they contribute to the health of AIAN communities, with guidance from the studies that have been done in the general population.

In terms of the federal trust responsibility, a significant proportion of the health problems that AIAN suffer from is related to the dramatic under-funding for Indian health care. Health disparities still exist, and well as disparities in the quality of and access to health care for AIANs. I found practicing medicine in the Indian Health Service very frustrating because I could not provide the same level of health care to my patients as I did when I was a medical student and resident at Harvard. Our facility was lacking basic, updated equipment, and subspecialty care was two hours away. While I believe that there are many dedicated health care providers working in the IHS, I also know that they can't provide the very best care for AIANs due to the limitations in funding for Indian health care. There is clearly a need for more funding to provide health care services to AIANs to provide them with the highest quality of health care possible.

7. What type of role do you think traditional healing has in modern medical practice?

Traditional medicine clearly has a very important role in the care of AIAN patients. Many AIAN still use traditional medicine as a source of health care, and for some of them it is their primary source of health care. The Association of

American Indian Physicians includes in its mission statement its wish to help promote traditional medicine practices, and provides education on traditional Indian medicine for health care providers and students. Many of our members believe that health care providers should work more closely with traditional healers and partner with them in the care of AIAN patients. Many view traditional healers in a similar role as other sub-specialists with which they consult, and honor the wishes of patients who want to include traditional medicine as a part of their health care. While not all AIAN use traditional medicine, we believe it should be respected as a valid option in the health care of AIAN patients who request it. Indian health care programs should include an orientation on the local customs and traditions of its population for new health care professionals, and an understanding of the importance of traditional medicine in the lives of the people from the community served. In addition, health care providers must understand potential interactions and side effects of traditional medicines in order to understand the effects of these medicines on their patients, and to avoid any adverse drug interactions.

The Association of American Indian Physicians offers workshops on traditional medicine for health care providers, and is willing to offer them to Indian health programs as a method of orientation of their health care providers to traditional medicine. Our only limitation to offering this training is the cost of transportation of our members and traditional healers to teach at programs around the country. We therefore support more funding for education and orientation on traditional medicine and the important potential role it plays in the care of AIAN individuals. In order to provide the highest quality of health care to AIAN patients, health care providers need to understand the role of traditional Indian medicine and how they can respectfully partner with traditional healers in their community.

Thank you for the opportunity to respond to your questions related to my testimony on May 10, 2000. If you have any further questions on the answers to your questions, feel free to contact me.

Sincerely,

Yvette Roubideaux

Yvette Roubideaux MD MPH
President, Association of American Indian Physicians
Clinical Assistant Professor, College of Public Health
University of Arizona

Testimony of the Quentin N. Burdick Indian Health Program

before the United States Senate Committee on Indian Affairs

May 10, 2000

Good Morning Mr. Chairman and members of the Committee, I am Barbara Dahlen, MS, RN, FNP, Assistant Coordinator of the Recruitment and Retention of American Indians into Nursing (RAIN) Program which comes under the Quentin N. Burdick Indian Health Programs at the University of North Dakota. The three programs include INMED (Indians into Medicine Program), RAIN and INPSYDE (Indians into Psychology Doctoral Education Program). I am an enrolled member of the Turtle Mountain Chippewa who resides in Belcourt, North Dakota. I would like to thank you for the opportunity to address the re-authorization of the Indian Health Care Improvement Act.

A partnership was created when the Congress of the United States gave the three programs at UND the mission of helping alleviate the shortage of American Indian health professionals. The programs created and supported through the Quentin N. Burdick Indian Health Programs, INMED, RAIN, and INPSYDE have created educational opportunities for Indian students that would not have existed otherwise. Equally important, these programs have developed partnerships with Tribal Colleges and Tribal officials, with various aspects of the university and other agencies and projects to enhance the opportunities and strengthen the educational base to promote success of students recruited to these programs.

The programs at the University of North Dakota have proven themselves to be very successful as the data we are providing will show. An issue that impacts greatly upon the ability of these programs to continue this record is the fact that funding to the programs has been decreased significantly - in real dollars, not just by inflation. Recruiting and retaining students is an intensive process.

The programs have been excellent stewards of the funds they have received. The impact of these funds is far greater than just upon the students in the programs. Partnerships developed with Tribal Colleges have helped these colleges build up their courses to strengthen the preparation of students transferring to senior universities. This has been done with Tribal Colleges at Fort Totten, ND, Fort Peck, MT, and Fort Berthold, ND. Such efforts support all students who attend these colleges and help the colleges meet regional accreditation standards, thus facilitating transfer of courses to other colleges and recognition of individual college programs. Another example, of partnering is the partnership with Sisseton-Wahpeton Tribal College. Nursing students from UND for whom the ladder approach to the baccalaureate degree in nursing is the most appropriate strategy transfer to Sisseton-Wahpeton then upon completion of that program and passage of the licensing examination, return to UND to complete the baccalaureate component. Partnerships with local scholarship programs such as Transcends and the UND tuition waiver program further stretch available resources.

These programs are successful. They are cost-effective. They provide opportunities for Indian students. They are beneficial to Indian Country. We thank you for the opportunity to present to the committee these success stories, and request that the programs continue within this legislation so that these successes can be multiplied.

INMED

The Indians into medicine program (INMED) is an academic support program directed to address the substandard health conditions that exist in American Indian communities by increasing the number of American Indian health professionals that serve these communities. INMED, at the University of North Dakota School of Medicine, has been in operation since 1973 and has graduated approximately one-fifth of the Indian medical doctors in the United States who are enrolled members of federally recognized tribes. In addition, the program has academically assisted and graduated nursing and allied health care professionals.

The program is located where health care professional needs are the greatest, and INMED maintains an affiliation with the 24 reservations in North Dakota, South Dakota, Montana, Wyoming and Nebraska. Representatives from each of these Indian reservations are appointed by their respective tribal governments to serve on the INMED Tribal Board. These representatives are instrumental in the development of Program policy and assure that INMED continues to be a significant resource that address's their health care needs. This Board also serves as an important linkage for student recruitment and placement, and maintaining responsiveness to the Indian community.

INMED has made an impact. As of this year the program will have graduated a total of 122 medical doctors and 115 nursing and allied health care professionals. Approximately 85% of INMED's graduates have used their training to provide direct health care services to American Indian populations, or they are obligated to future scholarship service paybacks pending completion of residency programs and/or placement at Indian health priority need areas.

INMED offers educational support for students from the elementary through professional school levels. This comprehensive approach distinguishes INMED from most other educational assistance programs. Over 110 students each year participate in INMED's academic year support program. Another 100 students attend INMED's annual summer enrichment sessions at the junior high, senior high and medical preparatory levels. These summer programs bolster participants' math and science backgrounds, introduce them to health careers and provide INMED with a constant pool of applicants for college level programs.

INMED is fully institutionalized within the UND School of Medicine. The program has department status, and an entire wing of the Medical School North Unit building (6615 sq. ft.) has been allotted for INMED offices, library, study areas, and seminar room. A Medical School Advisory Committee of seven faculty members oversees INMED activities.

INMED has also involved itself in creating formal partnerships with other educational systems to create educational opportunities for American Indian students. One of these arrangements is a cooperative program with the University of South Dakota School of Medicine. An INMED Satellite Office at USD began operation in 1990. The USD office assists in the recruitment of Indian students in South Dakota and operates an Indian student support program at the campus in Sioux Falls. Up to two University of North Dakota INMED medical students transfer each year to South Dakota to complete their third- and forth-year of medical training.

In addition to this partnership, INMED has formally involved itself in a partnership with White Earth Community College, Leech Lake Community College and Northwest Technical College in Minnesota.

Under this agreement, Indian students are recruited from the White Earth, Leech Lake and Red Lake Indian Reservations into a pre-medical / clinical lab science curriculum. The student will attend the first year of college at White Earth or Leech Lake and then transfer to Northwest Technical College in East Grand Forks, Minnesota to complete the second year of education. The student will then transfer to the University of North Dakota for the final two years of undergraduate education. Upon graduation, the student will be qualified to begin a professional career as a clinical lab scientist (medical technologist) or continue on to medical school.

INMED has also recently submitted a proposal to enter into a formal partnership with Oglala Lakota College on the Pine Ridge Indian Reservation of South Dakota. If this proposal is sponsored, INMED, in cooperation with Oglala Lakota College, will conduct academic activities in the K-12 school system on the Pine Ridge Reservation. Students will then been recruited to Oglala Community College for their first two years of pre-medicine and then transfer to the University of North Dakota to complete their premedical bachelor's degree.

Finally, INMED has just recently entered into a formal relationship with the Mayo Clinic. Under this arrangement, INMED medical students will be afforded the opportunity to participate in ongoing cancer research at the Mayo Clinic. The physician responsible at the MAYO Clinic for this research is herself a graduate of the Indians into Medicine Program, Dr. Judith Salmon Kaur.

In summary, INMED is a successful program that has been emulated internationally. We have been extremely successful in training qualified American Indians in not only medicine but in a variety of allied health fields including physical therapy, clinical lab science, medical social work, counseling psychology, nursing, and dietetics. To date, 237 American Indians have obtained their professional degrees with the assistance of INMED. The INMED Program, however, goes far beyond the typical concept of training health care professionals. We enroll, retain and graduate students in support roles necessary to operate a health care facility such as in records management, business administration, medical social work, computer science and civil engineering.

INMED successfully enables Indian students to establish academic and personal readiness for college and medical school. The program enrolls these students in the proper curricula, and provides valuable support services which results in qualified health care professionals to address the serious health care issues facing American Indian people.

RAIN

- In 1990, RAIN was one of the four original funded Sec. 112 nursing grants. The four programs were UND, Salish Kootenai College, Arizona State University and SUNY- Buffalo. Since that time five other programs were funded of which two have been discontinued. The intent of the law was to increase the number of nurses at the baccalaureate and masters levels prepared to provide health care to Indian people.
  In order to depict the success of the RAIN program at the University of North Dakota, qualitative and quantitative will be provided:

- **Quantitative Data**

  ✓ **1948-1990**, University of North Dakota College of Nursing established; 42 students

admitted; 18 American Indian (AI) students graduate with BSN; no AI nurses admitted to graduate nursing program

- ✓ **Fall 1990-Spring 2000**, RAIN Program established; **100th** AI student admitted to CON (total of 142); graduated 70 AI BSN students (total of 88).
- ✓ **Fall 1992-Spring 2000**, 16 AI nurses have graduated with master's degrees in nursing. **Currently,** 8 enrolled in the graduate nursing courses, 25 students enrolled in nursing curriculum, and 10 pre-nursing students

- ✓ Most significant is the decrease in attrition rate seen with the RAIN Program. Prior to the program being established, the attrition rate was about 20 percent. Currently, attrition is at 7 percent.

- **Graduates work in Indian Country**
  - ✓ 90% of BSN graduates work in Indian Country
  - ✓ 93% of master's graduates work in Indian Country
  - ✓ 1990 vacancy rate at Belcourt IHS facility was 63%, now 20 RAIN graduates, including 5 master's prepared nurses are there
  - ✓ 7 Directors or Assistant Directors of nurses at several IHS facilities
  - ✓ 4 Faculty positions in Minnesota, North Dakota, South Dakota
  - ✓ Chief nurse consultant, Aberdeen Area IHS
  - ✓ Women's health consultant, Aberdeen Area IHS
  - ✓ 2 family nurse practitioners

- **Graduates are academically successful**
  - ✓ Completed doctoral education (one of 15 doctorally prepared Indian nurses in US)
  - ✓ Entered and completed master's education

- **Program elements**
  - ✓ Scholarships and financial aid assistance. All students have had some sort of assistance - IHS, RAIN, UND tuition waivers, foundation grants, etc.
  - ✓ Accepting and supportive environment to promote a sense of belonging
  - ✓ Indian nurse mentors
  - ✓ Close academic monitoring and aggressive advisement
  - ✓ Open door policy
  - ✓ Value clarification
  - ✓ Cultural awareness of college faculty and students
  - ✓ Indian staff and professional role models

- **Cooperative activities**
  - ✓ Work with Tribal Colleges to improve pre-nursing courses to enhance transferability and student success at UND
  - ✓ Partnering with Sisseton-Wahpeton Tribal College for nursing career mobility

- **Qualitative Data**: Personal Vignettes

Retaining the students after recruiting them is very labor intensive. It involves a comprehensive 24 hour open door policy. It means creating a sense of belongingness within the College of Nursing. It involves creating a feeling of extended family. It involves valuing the diversity that the students bring with them,

and giving unconditional acceptance. Retention involves believing in increments of success. It means being involved in all aspects of their lives. RAIN becomes their home away from home. Below are personal stories that reflect how students feel about the RAIN Program.

1992 BSN, Turtle Mountain Chippewa. Prior to the start of RAIN, I struggled in every class. I had no support system other than two fellow nursing students. RAIN staff encouraged me to seek help at Learning Services after I realized I was having difficulty reading. Through testing , I learned I was dyslexic. Now, I could approach learning in a different way. In addition, the RAIN nurse mentor would come to my home and help me prepare for all my nursing exams. I was a senior nursing student by the time that I first received an "A" in a nursing course. I never believed that was possible. I went on to graduate and passed boards. I am successfully employed with IHS as a charge nurse. I believe without the assistance of RAIN this would not have been possible. They helped me to reach my dream.

1998 BSN, MS student, Oneida/Sisseton Wahpeton. I started out as a participant in the INMED summer institute while in high school. I started at UND, as a new freshman. Due to immaturity, I left school married and had two children. Some years later when I returned to school, I chose to attend College in Havre, MT. I had very little support from the nursing program and failed an adult health nursing course. I contacted the RAIN Program about transferring back to UND. I was admitted in the spring semester to the CON and moved my family to Grand Forks. I struggled with personal problems which caused me to take an LOA from the CON. During this time, the RAIN staff remained in contact with me, and monitored my progress for my return to school. I was away from school for a year and a half when I returned to school to complete my BSN program. I graduated in the spring of 98 and was admitted into graduate school in the Rural health nursing track. Through all my struggles, the RAIN staff never gave up on me. They never gave up on me, even when I gave up on myself. They supported me unconditionally.

1996 BSN, Standing Rock/Crow. While I was a pre-nursing student at UND, I did not have enough money to return to school to pay for my room and board and pay tuition and fees. I remember contacting Deb Wilson and telling her through tears that I wanted to come back but could not afford housing. She told me that I could stay with her and her family. I spent a semester at her home rent free. I earned enough money working part time and going to school to find an apartment with a friend the next semester. Without Deb's intervention, I have no idea where life would have taken me. After I was admitted to nursing, I became pregnant with my first child and had serious complications. RAIN arranged for the instructor of one of my nursing courses to teach one on one during the summer session to keep me on track. I am currently working with IHS on my home reservation. I feel without the support and commitment from RAIN, I would have never graduated. They continue to keep in touch with me and stop in at the hospital to visit when they are out recruiting. My future plan is to return to school to become a family nurse practitioner. I plan on returning to UND and the RAIN Program because of the support services they provide.

1992 BSN, 1995 MS, Three Affiliated Tribes. When RAIN began, I had been on an LOA from the CON. I had two children and was procrastinating. I knew I needed to finish my pharmacology in order to return to my nursing program. I would not have completed the program without the constant prodding of RAIN staff. When I returned to school that fall, the RAIN Program was new to me. I never dreamed of the intensity of services that the program would provide. One Christmas, we were so hard up for money that I new I would not be able to provide any gifts for my children. Deb and Barb showed up at my door with gifts and food. They showed me their commitment to student retention. This act and many others gave me the courage to stay and complete the master's program in rural health nursing.. I am very proud to say I am a RAIN graduate. I am currently working at an IHS facility in Minnesota

1994 BSN, Wind River Arapahoe. When the College of Nursing started the RAIN program I was on an LOA and was contacted during the summer by Barb Dahlen about returning to school. I knew that this would be impossible because I had a huge accounts receivable bill at the university. RAIN worked the entire summer to arrange a payment program that would ensure the University would recover the money owed. With this agreement I returned to school and finished my nursing program. This would not have been possible without the support of RAIN.

1995 BSN, 1998 MS, Turtle Mountain Chippewa. Prior to pursuing nursing as a career choice I was in construction work as a laborer and roofer. I worked long hard hours and the future was not very bright. I am a single father of four children and I knew that supporting them would take a career change. I have two sisters who were in the nursing program through the RAIN Program. They felt I would make an excellent nurse so I contacted the RAIN Program. My two sisters both went on to complete their MS degree through the RAIN Program. I was admitted to the program and received great support. I was successful in completing the program but when it came to the RN NCLEX examination I had difficulty and consequently failed 4 times—Through RAIN support it was identified that I had severe anxiety so they arranged for me to take a therapeutic relaxation independent course with a faculty member and see a doctor and be put on an anti-anxiety medication 1 month prior to boards—I passed with flying colors—only the continued support I received allowed me to believe that I could pass. I have since gone on to complete the master's program and I am the supervisor of the clinic at an IHS facility in North Dakota.

2002 BSN, Crow. I am a sophomore nursing student who moved to North Dakota because of the recruitment efforts of the RAIN Program. This past semester has been very stressful due to the two deaths I had in my family which required me to return to Crow. During the last trip my car engine gave out. My uncle gave me a ride back to UND with my two children. I needed a vehicle to get my child to school and my son to daycare so that I could attend clinicals at the hospital at 6:30 in the morning. The RAIN staff was able to locate a used vehicle that I call the "Titanic". At their own expense they went to Fargo and picked up the vehicle. They arranged a small loan of $350 to purchase it. I do not have to start re-paying the loan until my financial situation is secure. The two times I had to return home, RAIN staff gave me money out of their own pockets to travel. They have been there for me and my family every step of the way. I know I can count on them.

Spring 2000 AD-RN, Turtle Mountain Chippewa. I was a junior second semester nursing student in the CON program when the courses became more difficult. I did not feel I could continue in the nursing program and be successful. RAIN staff discussed with me more options for continuing in nursing. I was informed that the previous semester they had formed a partnership with the Sisseton Wahpeton Community College AD-RN program. The RAIN program stressed their increments of success philosophy. The partnership has allowed me to transfer and work on completing the two year RN program. I know I would have failed out or dropped out if it was not for the RAIN Program. I still have the option of returning to UND in the future to work towards a BSN if I should choose.

Spring 2000 AD-RN, Spirit Lake Sioux. I will be the first RN from my reservation. I have been a participant of the RAIN Program since the summer of 1995. I came in as a pre-nursing student. I went as far as a first semester senior nursing at UND. Due to many personal problems, high anxiety and panic attacks, I withdrew from UND to pursue the AD-RN program at Sisseton Wahpeton Community College. Over the years, I have given the RAIN staff many reasons to give up on me, but they **never** have. They continue to call me and knock at my door with options to be successful. They have bought my groceries, bought gas for my car, helped me buy a car, and these are only a few of the many examples that I could tell you about. I could fill pages and not be able to show the gratitude I have for the women of RAIN.

They let me rant and rave. They calm me down. I am a true example of how much the RAIN staff has had to deal with. I will always be connected to the RAIN Program. I have been given an opportunity that I never dared dream possible. I have always found it easier to accept failure. Success was something I feared. Now I see I am going to graduate in a few weeks and I feel such a sense of accomplishment and pride. I'm still scared because I have to pass boards yet, but I know RAIN will be there with me every step of the way. Even if I stumble.

These stories are only a select few of many that could be told. The heart and soul of the RAIN Program belong to Deb and Barb.

University of North Dakota Indians into Psychology Doctoral Education (INPSYDE) Program

Status Update and Needs Projection: May 5, 2000
J.D.(Doug) McDonald, Ph.D., Director, UND INPSYDE Program

I. Brief Background and Needs.

American Indians are the most underserved minority group in America in terms of physical and mental health care. Despite suffering depression- and substance-related disorders and suicide at rates five to 10 times higher than the majority culture respectively, they graduate the fewest percentage of mental health professionals each year. The Indian Health Service (IHS) is historically understaffed and underfunded to meet the overwhelming mental health needs of American Indians. The ratio of Indian psychologists to the general Indian population remains lower than that for any other minority group, and certainly lower than that for the majority culture. The total number of American Indians with Ph.D.s in clinical psychology is still under 150 nation-wide. To date, only six American Indian psychologists are professors within American Psychological Association (APA) accredited clinical psychology training programs.

The UND INPSYDE Program

The Indians into Psychology Doctoral Education (INPSYDE) program was established (Senate Bill 2412) in 1992 to begin addressing these needs. The University of North Dakota was chosen as the optimal site for development of the first INPSYDE program by APA, but the program remained unfunded until last year. The UND INPSYDE program's objectives are to increase the number of doctoral-level Indian psychologists, as well as the development of cross-cultural competence in non-Indian students and faculty. Training toward a Ph.D. in Clinical Psychology typically lasts 5 - 6 years.

Funding Status

The UND INPSYDE Program received its first year of funding through IHS in July of 1996 at $200,000 per year.

Achievements to Date

The funding has been used to address all legislative mandates, including recruiting, retention, increased awareness of careers in psychology, and cross-cultural competence enhancement. Eight Indian graduate students are currently enrolled at UND, with six other placed in APA-accredited clinical programs elsewhere in the region. If this class of students **alone** matriculates as expected next year it would represent a 5% increase in the total number of American Indian clinical psychologists nation-wide. To date, the UND INPSYDE Program has produced two Ph.D. and 6 M.A level psychologists.

What is the next step?

While the INPSYDE program has been successful in its first four years, continued legislative support in the form of reauthorization of the Indian Health Care Reform Act and appropriations are vital to its survival. An increase in appropriations has been proposed for FY 2001.

American Indians are the most underserved minority group in America in terms of physical and mental health care. Despite suffering depression- and substance-related disorders and suicide at rates five to 10 times higher than the majority culture respectively, they graduate the fewest percentage of mental health professionals each year. The Indian Health Service (IHS) is historically understaffed and underfunded to meet the overwhelming mental health needs of American Indians. The ratio of Indian psychologists to the general Indian population remains lower than that for any other minority group, and certainly lower than that for the majority culture. The total number of American Indians with Ph.D.s in clinical psychology is still under 150 nation-wide. To date, only six American Indian psychologists are professors within American Psychological Association (APA) accredited clinical psychology training programs.

Mr. Chairman, the Quentin N. Burdick Indian Health Programs supports the work of IHS, particularly their commitment to providing quality programs to educate health care professionals. Thank you for the opportunity to share with you our concerns regarding the re-authorization of the Indian Health Care Improvement Act. Our success is attributed to the IHS support as well as the commitment of the colleges and their president's and faculty. We believe all three of these programs are essential avenues for the education of American Indians.

UNIVERSITY OF NORTH DAKOTA

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June 14, 2000

Senator Ben Nighthorse Campbell, Chairman
United State Senate Committee on Indian Affairs
Washington, DC 20510-6450

Dear Senator Campbell:

In response to Question 1, Can our program be successfully duplicated on other campus? Yes, our program could be duplicated. To be successful, a program needs to have American Indian support staff, who have had the same lived experiences as the students. The students appreciate that someone else has been through and understands what it takes to commit to leaving home and pursuing their goals. It takes going beyond the eight to five work day. It means being available 24 hours a day. Helping students to be successful is very labor intensive. It means being involved in all aspects of their lives. Its putting your heart and soul into what you are doing with the students. You become mom, grandma, aunt to the student and their families, no matter what the age. It means accepting the students unconditionally. It means you never stop believing that the student can be successful even when they don't believe. Too often our students are more apt to accept their failures than their successes. Its hard for them to acknowledge and accept that its okay to be successful. Its making the student see a setback as just another opportunity. Its being a student advocate and making the students realize that they have options and they are responsible for their decisions. Its helping the students learn to balance their two worlds. Its creating a sense of belonging and a place where students feel they are welcome. Its having a place where there can be tears and laughter.

It takes a commitment from the parent institution for recruitment and retention. This commitment must be expressed in actions not just on paper. For example, it may mean having directors, who may not be American Indian, giving the staff the freedom to do their job and develop strategies that are appropriate for retention. It's having faculty who understand staff's role as a student advocate and are willing to be a part of the process. It's pleading with a faculty to be flexible, requesting they let a student redo a paper to raise a grade or having them understand that we can keep a student on track and in school even if they have had to go home twice in a month due to deaths in the family. It's having a financial aid officer dedicated to juggling the loans and bottom lines to get students through each semester. It's having a business officer willing to lift the hold on a student account so the student can get registered and get their financial aid. It's having the housing officer find emergency housing, or not evicting a student and willing to work on a payment plan. It's having a university president willing to give us tuition and fee waivers for our scholarship students because our budget cannot be stretched to cover these

costs. It's having a college dean who will waive the program fees so we can stretch scholarship dollars. It's having private benefactors who will send us contributions to pay for students taking courses off campus. It's working with the instructors at tribal colleges to offer courses that will fit into our students' schedules or having them work independently with a student to retake a course. It's working with tribal higher education officer to fund beyond what they have budgeted a student. It's a grants management officer at headquarters letting you request dollars for coffee if it means retaining students. It means just because it hasn't been done before that you can't make it happen. Sometimes, it means looking beyond the rules and regulations to make a difference. It's realizing if our program was not in place, that we would not have the number of students completing their nursing degree.

A program could not be successful without all these components and more. We could not do our job if we did not have all these resources in place. It does take a village to raise a child. This is evidenced by the development of the RAIN Dreamcatcher/Medicine Wheel Model of Retention. It's the webbing that depicts the complexity of services required to retain American Indian students. Our program's workings and success goes beyond what is written in the goals, objectives and evaluation plans for the project.

In response to Question 2, the annual budget of our program? Our annual budget for the 2000-01 funding cycle is $159,701. As could be expected, we were very disheartened and disappointed in the continued reduction of our 2000-01 budget allocations. We were hopeful that the $21,500 that we had to cut from our operating budget the prior year would be reinstated. This did not happen. It is ironic that when RAIN was initially funded we had a higher level of funding and we were handling only a fourth of the students we are working with presently. For the 1999-00 academic year, we had 11 pre-nursing students, 24 baccalaureate nursing students, 4 associate degree nursing students and 8 graduate nursing students. We are still providing the same quality of services for more students with fewer operating dollars.

We have cut our recruitment travel tremendously for this coming year. Our travel has gone from $14,471 down to $3,377 in the last two year. We are quite certain that this action is going to impact our recruitment efforts. Yes, we know that RAIN is well known. This is because we have been visible out in Indian country recruiting. The fact is, people out in Indian country want to see our faces and not just hear our voices on the telephone (if they have a phone). They want us to know where they come from. They want us to meet their families. It will have taken the University and the College of Nursing 52 years to graduate our first bachelor prepared nurse from the Spirit Lake Nation of Ft. Totten, ND. This is the closest reservation to the University. The student will graduate in December 2000. It took the RAIN staff three years to recruit her before she actually came to the University three years ago. It was making sure that we stopped in and visited with the student every time a trip was made to the reservation. This could not have been done with just making phone calls or writing letters. Our operating budget would be in worse shape if it were not for the University agreeing to reduce indirect costs to 4%, instead of the usual eight percent.

Our scholarship dollars have always remained the same: $115,500. We have to wait until someone graduates before we can award new scholarships. We are definitely feeling the crunch with the RAIN scholarships. With the stipend and tuition cost increasing this year with no

increase in allocation we know we are only going to be able to fund seven continuation students this fall rather than the 10-12 we have funded in the past. It is very hard to recruit new students when there is no hope of them getting a scholarship from RAIN or the IHS 437 scholarship programs. It would be helpful if at some point we could freeze the stipend amount to stretch our scholarship dollars. We already request the University charge only in-state tuition on our out-of state students. It is also important that you realize the RAIN Program is further supported through private donations and a variety of university and college contributions, however, these in no way compensate for the ongoing budget reductions from IHS.

In response to Question 3, why do the vast majority of our graduates stay in Indian country and serve tribal people. We believe it is because we recruit the students from the reservations. They have lived experiences with reservation life. They have a strong commitment and connection to real people and places. They see the turn over of physicians and see that it is the nurses making the long term difference in the health of their people. Their sense of belonging to their communities is stronger because they return to the reservation sooner to work and take care of people than do the physicians. A nursing student is away from home for three or four years compared to a medical student who is away from home for a minimum of 12 years. Nursing students have more opportunities to work at home in the summer time during their nursing program on the IHS Externship program, so their connection continues with home throughout their nursing program. Medical students do not have as many opportunities to return and work in their communities while they are going to school and receiving their training.

In response to Question 4, what else can be done to ensure that the number of American Indian and Alaska Native health professionals continues to increase? It is so important to continue the financial support of IHS Scholarship Program, and the programs like RAIN, INMED and INPSYDE. The scholarship support is so crucial to the success of our students. We have seen a tremendous difference in student's academic performance once they are awarded the IHS and RAIN scholarships. They know have some financial security and do not have to worry about how they are going to put food on the table for their children. They do not have to worry about having to work and lose study time. We have had students turn down admission to the College of Nursing because they cannot afford to attend school without scholarship support.

Another way to increase American Indian health professionals is to provide financial support for LPNs, AD-RNs, BSNs, to upgrade their education. We have been told by Nursing at IHS headquarters that within 5-10 years, IHS is going to be experiencing a nursing shortage crisis. There are **3,181** nurses in the IHS—Overall, **877** are over the age 50 years old—**1,180** are between the age of 40-49 years old—only **1/3** (less than 1000) are American Indian.

In response to Question 5, do we attribute the success of the INMED Program to the fact that this programs follows students from high school through undergraduate and medical school? Yes, and actually they start following students from the junior high school level. There is no greater sense of personal pride and accomplishment than to see some of the physicians and nurses working out there in Indian country and to know that you knew them when they were in junior high and high school and that you had a small part in what they are doing today.

These summer enrichment programs are so crucial to the goal of increasing the number of American Indian and Alaska Native health professionals. These programs offer the academic enhancement needed for students to be successful. They offer an early exposure to campus life and support services available. These young people are able to see Indian college students at different levels in their pre-professional and professional programs. These programs are the future of Indian health care delivery. We would like to provide such a summer program for pre-nursing students, however, we have not been able to secure funding. The INPSYDE program has a summer component- one that faculty and staff believe is crucial to the student's academic success. The cost of providing these types of programs is great for many reasons - recruitment, student support, travel, planning, etc.

I am honored to be able to respond to your follow-up questions. I thank you for giving me the opportunity to speak in support of the reauthorization of the Indian Health Care Improvement Act.

Respectfully,

Barbara Dahlen

Barbara Dahlen, MS, RN, FNP
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TESTIMONY OF GERALD DANFORTH TO THE SENATE COMMITTEE ON INDIAN AFFAIRS

Good morning Chairman Campbell, Ranking Member Inouye, and members of the Committee. My name is Gerald Danforth, and I am the Chairman of the Oneida Tribe of Indians of Wisconsin, a federally recognized sovereign tribal government representing approximately 14,000 members, located just west of Green Bay, Wisconsin. I want to thank you for the opportunity to appear before you today.

Mr. Chairman, as you know, there is a tremendous shortfall in resources for Native American health care. This is why it is necessary for the Indian Health Care Improvement Act be reauthorized. I would first like to discuss Oneida's participation as one of the delegates to the National 437 Steering Committee (Public Law 94-437, Indian Health Care Improvement Act). As a participant on the steering committee, the Oneida Tribe took great interest in contributing to the redrafting of Title III, Health Facilities, and Title IV, Health Care Financing. I would also like to take the opportunity to address the current shortfall in funding for new health facilities, its impact upon the health of Oneida members, and a proposed innovative solution to that problem.

NATIONAL STEERING COMMITTEE: Reauthorization of the Indian Health Care Improvement Act

In June of 1999, the Indian Health Service convened a National Steering Committee made up of the IHS, Indian governments, and urban Indian organizations. The initial plan for the National Steering Committee was to develop broad concepts and general ideals for the distribution of federal funds for Indian health. After the initial meeting, however, the National Steering Committee decided to tackle a comprehensive redraft of the Indian Health Care Improvement Act based on the consensus recommendations developed at four regional consultation meetings. The members of the National Steering Committee and its staff put in thousands of hours into the draft of the Indian Health Care Improvement Act. The final proposed bill was presented in October of 1999, to the Director of the Indian Health Services and to each authorizing committee in the House and Senate.

The National Steering Committee allowed the Indian Nations of the United States, including the Oneida Tribe, to have a powerful voice in the amendment and renewal of the preeminent Indian health care law. The Oneida Tribe devoted the time of its government officials, health care administrators, and attorneys to the National Steering Committee, and we are satisfied with the resulting draft. The Oneida Tribe fully supported and continues to support the proposed Indian Health Care Improvement Act reauthorization amendments as the most feasible solution for the advancement of Indian health.

JOINT-VENTURE PROGRAM: Solution to Shortfall in Health Facilities Funding:

According to the five year IHS Health Facilities Planned Construction Budget, there is a $938 million need for new construction of health facilities in Indian Country. Considering current funding levels, even those tribes who manage to secure a spot on the very exclusive IHS Health Facilities Construction Priority List today could have to wait 60 years for their facility to be built. As a consequence, the existing health facilities are outdated (average age - 32), difficult to maintain, inadequate, and in desperate need of replacement.

Inadequate facilities and lack of access to medical care contribute to the high rates of Native American deaths due to treatable health problems. According to the IHS, the death rates in the American Indian and Alaska Native population, as compared to the general population, are seven times greater for alcoholism, six times greater for tuberculosis, three and a half times greater for diabetes, and three times greater for unintentional injuries.

These frightening health statistics are some of the main reasons that the Oneida Tribe participated in the National Steering Committee's Health Facilities workgroup. We felt that the Oneida Tribe needed to become a leader in researching and creating innovative means to alleviate these health facilities concerns. The Oneida Tribe sponsored a meeting on the Oneida Reservation and invited numerous tribes to discuss alternative funding mechanisms for health facilities. These discussions inspired Oneida to become an advocate and leader for tribes interested in pursuing funding through

the Joint Venture Health Facilities Program.

In Oneida, our health department struggles to meet the demands of an increasing population in an aging building that is woefully undersized. In our two county service area alone, the existing Oneida Community Health Center has experienced an annual patient growth rate of 9.2% between 1990 and 1997. We now have three trailers sitting outside our facility, and we may have to add one more. Oneida patients and doctors alike must wait for examination rooms.

Patients must wait months for everything from medical, dental and optical services to emotional counseling services. Patients cannot get an appointment with a doctor at the Oneida Community Health Center for at least one month. The average wait for adult dental care is three months, and there is a three and a half month wait for basic teeth cleaning. Furthermore there is a two-month waiting list for optical appointments. The resulting inability to serve our members is devastating.

Our substandard service facility also creates an endless battle to hire and retain doctors and medical staff. We have had two physician positions vacant for the last four straight years, making it difficult to meet the needs of our population which has high incidences of diabetes, cardiovascular diseases, and respiratory problems. All of these problems require a higher level of care than mid-level practitioners are capable of providing. The alternative of purchasing the services of doctors in the Green Bay area clinics is prohibitively expensive.

Because of the lack of federal funds, however, the Oneida Tribe will have to wait at least two generations for the federal government to construct a new facility. We cannot afford to sit idly by while our people suffer needlessly.

Our proposed solution is joint venture. We will finance the construction of an adequate facility if the IHS will equip and staff the facility. The Oneida Tribe, along with other members of the Tribal Nations Joint Venture Coalition, are working to develop and construct facilities with funds they would generate by bonding or through other governmentally-secured promissory notes. If IHS were

to assume the costs associated with equipping and staffing these facilities through cooperative agreements with the Tribes it would be possible to construct appropriately-sized and equipped facilities to provide adequate health services.

Such IHS equipping staffing is already authorized in law as the Joint Venture Demonstration Program. The proposed amendments shorten the no-cost lease to the IHS provisions in the Joint Venture. This provision makes it possible for more tribes to show financial viability and participate in the program. With adequate funding for the Joint Venture program, three or four tribes annually could complete the construction of their facilities, putting them up to sixty years ahead of schedule.

In Oneida, the Impact would be tremendous. With a new and expanded health center, the Oneida Tribe could increase the number of diabetes prevention and treatment visits by over 140% in the first year alone. Other categories of medical need could be similarly boosted. Our general medical clinic is currently providing only 68% of the visits needed. The number of visits would increase by nearly 10,000 visits in the first year alone if an adequate new facility was constructed. Our dental, optical, and women's health departments would also be able to double their number of visits annually, thereby reducing the current long lists of waiting patients, and getting preventive care to people before their conditions become serious and more expensive to treat.

Mr. Chairman, the Oneida Tribe of Indians of Wisconsin, the numerous members of the Joint Venture Coalition for Health Facilities, and other tribes look forward to working with this committee to develop viable alternatives to the current dramatic health needs in Indian Country. Meaningful cooperative agreements such as the Joint Venture program outlined in the proposed Indian Health Care Improvement Act provide an appropriate and focused approach that can move us beyond the desperate situation that currently exists. The Oneida Tribe strongly encourages you to support funding for the Joint Venture Program proposal, and we ask that you encourage your colleagues on the Appropriations Committee to do the same.

Oneidas bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the colonists had consistently refused to aid them.

Oneida Tribe of Indians of Wisconsin
BUSINESS COMMITTEE

JUN 20 PM 4:43

UGWA DEMOLUM YATEHE
Because of the help of this Oneida Chief in cementing a friendship between the six nations and the colony of Pennsylvania, a new nation, the United States was made possible.

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June 15, 2000

The Honorable Ben Nighthorse Campbell
United States Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

RE: Responses to Joint Venture Questions.

Dear Senator Campbell:

Thank you for your inquiries on the Oneida position on joint venture. We look forward to working with you and the Senate Committee on Indian Affairs to enact the joint venture language of the Indian Health Care Improvement Act. Hopefully the following will provide adequate answers to your questions:

Question: *In your testimony you mention that the IHS construction priority list is exclusive. Why or how are tribes excluded?*

The IHS Health Facilities Construction Priority List is exclusive in that only those locations with a "federal presence" or locations have an existing federal facility meet the criteria for replacement. It is extremely rare that any new facilities qualify for placement on the Priority List. There is a 35 year "backlog" for those locations already on the Priority List. Therefore is no opportunity for additional facilities to be constructed or reconstructed. The need for new facilities far exceeds the funding.

Question: *How many tribes are in the Tribal Nations Joint Venture Coalition? Are all these tribes willing to use their own funds to building their own facilities?*

When the Tribal Nations Joint Venture Coalition was formed, fourteen tribes were present at the meeting held in Oneida, Wisconsin. Eleven of those tribes sent in tribal resolutions supporting the efforts of the group, and the other three did not feel they were ready to make the monetary commitment at that time. The list has now grown to twenty-seven (27) supporting tribes. Some of the twenty-seven could not wait for authorizing legislation, and

they have moved ahead with funding their own facilities. Their health care needs were so dire that they could not afford to wait for the federal government to meet its trust obligations.

Question: *If the Joint Venture Program were to be funded, would tribes be willing to assume partial costs for staffing for the facility, all of which would eventually be assumed by the IHS? For example: would the tribe build a facility then pay an increasingly smaller percentage of the staff costs over a period of five years - 80% the first year, 60% the second year, etc., until they pay nothing for the staff or equipment and the IHS assumes all the costs?*

The Joint Venture Program was developed for the purpose of sharing between an individual tribe and the federal government the costs of the construction, staffing, operating, equipping, and maintaining health facilities. If tribes were to pay for the design and construction (approximately ten to fifteen million dollars) of their respective facilities and then pay the initial costs of staffing, operations, and equipment; there would be no "joint venture." This proposal would, in effect, pay for the trust obligation of the federal government with tribal dollars. I do not believe this would be a viable option.

I hope my answers can be of some help to you. Please feel free to contact me if you have any questions on my comments.

Sincerely,

Gerald L. Danforth, Chairman
Oneida Tribe of Indians of Wisconsin

Testimony for Senate Committee on Indian Affairs

Presented by Douglas Eby MD MPH FAAFP
SCF VP Medical Services

Representing: Southcentral Foundation – Alaska Native non-profit health corporate arm of Cook Inlet Region Incorporated located in Anchorage, Alaska.

Outline

I. Introduction
II. Advantages of Local, Native Customer-ownership
III. SCF Steps to Transform Health Services
IV. SCF Plans for Further Improvement and Expansion
V. Role of the Indian Healthcare Improvement Act

May 10, 2000

It is an honor to be able to address this committee on behalf of the Southcentral Foundation Board of Directors, the President/CEO – Ms. Katherine Gottlieb, the corporate vice presidents and the staff.

I come to you as a corporate vice president and a physician administrator privileged to work for a Native corporation, Southcentral Foundation (SCF), in the service of the Alaska Native peoples of Anchorage, Alaska. SCF has a long history of developing and providing innovative, community based health programs and we are proud to share with you some of what we have been able to do.

The past several years have been particularly challenging and exciting as Alaska Native leadership have completed the process of transferring all remaining Indian Health Service programs in Alaska to Native ownership and management. This includes the transfer of the largest Indian Health Service facility and medical system in the United States – the Alaska Native Medical Center. We have then proceeded to transform the system into one that is becoming one of the finest anywhere in the entire country.

II. Advantages of Local, Native Customer-Ownership

There are many reasons why the transfer of ownership and management of programs previously under the I.H.S. has been a good thing for health systems. Some of them include:

Customer ownership – health systems are best when in the hands of those for whom they provide services. Healthcare is a service industry. Service industries are best when closely attuned to the customer and there is no better way to assure this than by putting the system in the hands of the customer.

Native ownership – the services SCF offers are for Alaska Native clients. Services offered by a Native-owned system are naturally going to be more Native appropriate.

Private corporate ownership – the change from being Federally owned to being a private healthcare corporation has opened a lot of doors. SCF has been able to add millions of dollars to provide expanded services through grants and contracts previously unavailable to the Federally owned system.

Local ownership – being a self-contained, local corporation provides the opportunity to be locally focused and more rapidly responsive than was possible with a large government system centrally controlled from 5,000 miles away. Our ability to understand local dynamics and to partner with other local groups has expanded our ability to provide services.

The improvements with 'Compacting' – the flexibility afforded SCF by the compacting relationship where SCF has considerable freedom in controlling and reshaping systems to be more appropriate to the local situation has allowed considerable improvements in service delivery.

In the following pages we describe what we have done in developing new programs and transforming those we have taken over from the I.H.S. The most recent example is what we have done in the past two years to completely transform the services we took over from the Indian Health Service at the Alaska Native Medical Center (ANMC) in the spring of 1998.

We spend considerable time learning about cutting edge ideas transforming healthcare nationally. We then adopt the best practices we find nationally, put them together in new ways, and adapt them to our system. By adopting and adapting the best healthcare system practices nationally and combining that with the wisdom and the strength of the Native community we have created the best of all possible worlds and are convinced *we are creating something very special and very impressive.*

One example of what we have done is that in the past year we have helped nearly 30 thousand clients choose their own primary care provider for them and their family, made it possible to see that provider consistently over time, and have *access to that provider for whatever they want when they want it.* It is now possible for these clients to call today and be seen by their provider today for whatever they need.

This system is also a *relationship-based system of care* where each visit builds on the previous one. Patients don't have to tell their whole story from the start over and over. It allows the primary care team and the client to get to underlying issues that really determine illness and health. These issues include such things as depression, substance use, violence, relationship difficulties, obesity, smoking, etc, etc. The opportunity to not just deal with the immediate crisis, but get to the real determinants of health and wellness finally exists.

Systems like this allow the provider, case manager, and client to get more real work accomplished every visit. Over time the patients' ability to do more for themselves and make their own healthcare decisions goes up. Patient satisfaction and provider satisfaction go up. Healthcare outcomes improve, ER visits go down, and hospital admissions decrease. Over time outpatient visits also go down. In other words efficiency improves while effectiveness improves and satisfaction of everyone goes up. It is possible to do. We are doing it.

We are also rapidly and effectively putting the health system *into Native hands* at all levels while developing highly capable Native leaders and increasing the availability of clinical staff by giving them better non-clinical support. In the past the I.H.S. system used doctors and nurses as the only managers in departments. We now have professional managers who are Alaska Native that we train in budget and personnel management in addition to all additional management skills. We allow the clinicians to return to predominantly clinical work while providing overall direction and we have added considerable business and personnel expertise to the clinical expertise already existing. *It is a change that has improved everything about how the system is managed while putting the system into Native hands and building highly capable Native leadership for the future.*

We have also taken all of our programs – developed and inherited – and made them into a planned, intentional system of care. Way too often healthcare consists of a bunch of loosely connected program 'islands' that create a lot of duplication of effort, poor hand-offs, and inefficient and ineffective care. We have outlawed 'islands', have instituted population based thinking and planning, and *have created a system of care that is centered around how it works best for the client and how the client wants it.*

Additionally we have taken the unique strengths of the Traditional Native way of doing things and added that to the predominantly allopathic medical system we inherited and developed. This includes the incorporation of Native ways and thoughts into our mainstream health systems. It includes the development of particularly Native programming that targets youth and adults in difficulties who need to rediscover strong roots and identity to move toward health. It has meant redesigning programs around the Native family and community. It has also meant investing heavily in helping all of our staff understand Native history, Native cultures, Native priorities, and Native ways.

We are convinced that publicly funded, well-managed healthcare systems in the hands of the customers are the most effective model for healthcare delivery provided there is effective and accountable management. Much of what is known as 'managed care' in the United States has resulted in conflicted incentives where the advantages of this approach are lost in the competing incentives of poorly designed systems. We believe we have demonstrated that when you align the incentives correctly and create the right combination of incentives, you can create truly impressive and effective healthcare delivery that produces amazing outcomes while improving efficiency and effectiveness.

The following pages list in brief, bullet form what we have done to transform our system. This is followed by a brief description of what else we intend to do if funding can be expanded.

III. SCF's Steps to Transforming a System of Healthcare:

At SCF we have undertaken a complete system transformation of what we inherited from the I.H.S. and incorporated it into what we developed ourselves. Changes have occurred in philosophy, structure, and direct services offered our customer-owners. The list below contains many of the elements that went into this system transformation and each is further defined in sections that follow.

Mission driven organization
Senior Management alignment and support

Unwavering customer focus
Customer-owner solidification
Population based approach to system design
Team Management
Intentional, planned Native management development and implementation
Business oriented management development
Access to care
Relationship based Primary Care Provider system
Case Management
Integration of Departments – System of Care
HR processes redesign
Aligned incentives throughout the system
Central Budgeting and Planning
Intentional Planned processes
Alignment of Processes
Improvements in Clinical Quality
Facilities
Effective Budgeting for the long term
Long term thinking and planning
Expanding rural ASU system of care
Continuum of Care
Development of partnerships and other sources of funding

1. Mission driven organization

Mission, vision and key points everywhere – on walls, pens, shirts, mouse pads.
Job Descriptions and evaluations based on these statements and values. For example, everyone in the organization – everyone – is evaluated on Team Contribution, Communication, and Professional Responsibility.
The entire management structure and decision making process has been revamped.

2. Senior Management alignment and support

The SCF Board, the CEO evaluation, the Board driven priorities, the corporate plans, etc. are all driven by the mission and key points. The Primary Care Plan being implemented was a product of customer, staff, management and Board input. It was approved and supported at all levels before implementation.
The Board and President/CEO themselves continually and strongly support the Mission and Key Points.
Communication, planning, and updates flow up and down the system continually in order to keep everyone aligned.

3. Unwavering customer focus

Systems were changed dramatically to bring services to the patient rather than have the patient go to lots of different locations.
Continual feedback and accountability regarding patient/customer experience.
Corporate wide expectation that things will go right.
Unwavering passion from CEO regarding a high performing system and intolerance of second best.
Active customer service team with many activities. Is a standing agenda item at every managers meeting.
Current development of the Patient Resource Center.
Development of Patient Advocate system in the hospital.
Development of greeters.

Development underway for short-term child support while adult receives care.

4. Customer-owner solidification

Transition from Federal system to Native ownership and oversight complete

Continual reminder to management and staff that the SCF Board ultimately controls the shape and priorities of the corporation.

Placement of Native managers in every department in Medical Services is completed.

5. Population based approach to system design

Departments in the Federal system of the past were basically employee centered. Work was defined as seeing those patients that managed to figure out the system well enough to get onto provider's schedules. There was created a constant tension between patient demand and employees 'protecting' themselves.

All departments now told they must think about the entire population they have expertise to offer and how best to deliver services to that entire population.

Departments are encouraged to think system wide and find ways to support others doing some of the work and reserving to themselves those things that only they can do.

Examples:

Mental Health – Now thinks of the entire Anchorage population, and to some extent the ASU and the entire state. They are working with PCP's (Primary Care Providers) and case managers in other departments to build their capacity to handle basic mental health issues. They have assessed how the customer uses the system and are in the process of redesigning their processes to match customer use.

Women's Health – They are working to create standardized care for women wherever they are seen – women's health, family medicine, urgent care center. They are focusing on standardizing and improving pregnancy care. They are working to develop ways to be more efficient and effective in their specialized areas of gynecology and gynecologic oncology.

Pediatrics – Similar to Women's Heath. They are working at standardizing and building capacity for children no matter where they are seen. They are developing a center of excellence around fetal alcohol affected children. They are building relationship based, continuity oriented, same day access capable primary care.

Family Medicine – Have created and implemented a relationship based, continuity oriented, case management empowered, same day access capable system for all adults in the ASU and all children who choose to use this system.

6. Team Management

Every department of significant size has a management team

The larger clinical departments have an outpatient clinic management team, an inpatient management team, and an overall physician medical director.

Decisions are by consensus and are to have included input from all levels of the department and are to have included consideration of the patient/customer.

Teams include clinicians and non-clinician professional managers.

Our nursing leadership have been instrumental in driving the creation of a shared governance system of nursing input across the campus.

The nursing shared governance process has created nursing councils that help standardize processes and align incentives.

The new Medical Staff Bylaws at ANMC create the structure and system for more activist involvement by the medical staff in quality of care.

7. Intentional, planned Native management development and

implementation

A system of advancement is in place. One can advance from Clerk I to Clerk II to Support Coordinator to Clinic Coordinator to Health Systems Administrator (levels I, II, and III) to Vice President.

Creation of Clinic Coordinators. These are office managers for most of the programs. These are, by definition, Alaska Native managers. They are mostly young, college graduate managers with little hands-on experience. Through an intentional, mentored process they develop into very capable, highly responsible office managers. These are now the day to day managers of the departments.

SCF has a well-developed program of support for those pursuing education and degrees. Time off of work is provided, support during pursuit of advanced degrees, and large amounts of non-degreed skill development is supported.

8. Business oriented management development

In the past managers of departments were doctors and nurses plucked from the current department. With the addition of full time clinic coordinators there are business-oriented managers in every clinical location.

Budgets are now developed with considerable department input. Budgets are then given to departments to manage.

We are starting to see department management see their operations as a budget rather than a collection of FTE's. There is still a long way to go.

We have worked to bring a higher priority to the revenue collections system.

9. Access to care

Our patients want access to services – above all else.

Our patients want access to their PCP. They don't want to have to tell their story over an over to new providers every time.

At SCF we now have PCP's whose job it is to meet the needs of their panel of patients. Over 25,000 persons in the ASU have chosen a PCP (or had one assigned in the case of rural villages).

The rule is 'do all of today's work today'. The only reason for a patient to not be seen today (for anything) is if the patient requests otherwise or it is a scheduled follow-up appointment. Same day access for anything the patient wants is the rule.

At present we are matching patients and PCP's in actual visits around 55-70% of the time (used to be 20-30%, national best practice is 65-75%) and every PCP's schedule is half-open at the beginning of the day.

10. Relationship based Primary Care Provider system

Sustainable, significant lifestyle change and effective patient education only occur in longitudinal relationship based systems. We have created such a system.

Every patient now sees their chosen PCP when they want to see them unless they are out of town. Every visit builds on the previous visit. This system allows the client and provider to get past the superficial issues to the underlying true determinants of illness and health.

The team of PCP, Case manager, floor nurse, patient and family is a critical component. Patient and family Self-Care is a cornerstone of this system.

11. Case Management

There is now a strong body of evidence to show that good, pro-active case management is essential to effective care of chronically ill and medically fragile patients.

There is strong evidence that hospitalizations go down, overall health care expenditures go down, quality of life goes up, patient satisfaction goes up, and provider satisfaction goes up in a case management oriented system.

SCF has integrated immunization money, diabetes money, and research grant money into the case management system. What has resulted is a one-to-one ratio of physicians and case managers.

Case managers coordinate village care, follow-up care for patients who are seen, and proactive case management for those for whom it is appropriate.

12. Integration of Departments – System of Care

The SCF Board and CEO have mandated an integrated system of care

SCF management has adopted a 'no more islands' mantra

The Federal system at ANMC ran the place a loose collection of independent, hardly accountable islands pretty much left to their own devices. SCF has outlawed such a system.

All departments and systems are to orient themselves to support the PCP/Case manager/patient/family partnership.

All specialty departments are to spend part of their time and energy building and expanding the PCP team capability.

All specialty departments are to creatively explore effective ways to create relationship with the PCP team.

Departments have entered into 'Service Agreements'. Service agreements define what each department will do and how they will relate to the other departments. For example Pediatrics and the Urgent Care Center have a service agreement that defines the role of each with children, how they will pass patients between themselves, how they will standardize and coordinate care, etc. These are now in place for the most part.

Nursing has developed its shared governance structures and processes. The nursing councils and associated activities are assuring integration and standardization of nursing activities across the campus.

Community education redesign to pull together 'islands' of previous I.H.S. programs.

13. HR processes redesign

Over the past several years every job description and every performance evaluation was rewritten to be in alignment with SCF mission and key points.

SCF is now well along the road of revamping the entire corporate system of personnel management. This will include further standardization of job categories and pay. It will include the implementation of an incentive pay system. It will include a redesigned performance evaluation system that is more objective and will require ongoing, continual management feedback to staff.

Aligned incentives throughout the system

The SCF system of same day access to the same PCP will work best for staff if they:

Help patients and family do more self care. So patient education and involvement is directly and tangibly rewarded.

Work as a team. Any physician who insists on doing everything themselves is going to suffer terribly in this system.

Phone management is rewarded. Saves the patient and the physician time.

Increased PCP knowledge and capability is rewarded. Specialists get direct benefit from working at this.

Every visit builds on the previous one.

Max-packing is rewarded – doing everything you can in this visit (prevents future visits decreasing the number of times the patient has to come in and the number of

appointments in any given day for providers).

Effective, pro-active case management is rewarded. Patients who are better controlled medically are healthier and come in less. Quality of life improves for patients and staff.

Prevention is rewarded. Illnesses prevented are patients needing less medical care.

Underlying root cause issues are addressed. Since every visit builds on previous ones trust is developed and there is time to address issues of depression, substance abuse, violence, obesity, lack of exercise, etc. In the short run utilization may increase, but over time it should decrease and health should be more likely to increase.

The system encourages and rewards the above actions directly in more manageable and satisfying professional lives. The feeling of treading water or constantly fighting a non-ending onslaught of patient demand goes away. The feeling of real progress is achievable.

Specialty departments are rewarded by supporting the PCP system of care. Their work becomes more manageable and rewarding.

The nursing self-governance process builds on and rewards participatory processes throughout the system. It also standardizes processes across the campus.

15. Central Budgeting and Planning

SCF requires every department to sell their requests for increases in language that describes how it would help the entire system of care.

There is effort to have all departments provide comment on the entire list of proposals.

All revenues go into a central fund and enhancements are mission driven, not revenue generation driven.

Planning efforts are around a system of care and defined corporate priorities drawn from the mission and key points.

All division and department goals are aligned with Board approved corporate goals.

16. Intentional Planned processes

The systems we inherited from I.H.S. were the way they were mostly because of personal passions, effective lobbying, and responses to crisis. In other words, mostly an accident of history.

We have mandated a system of care – intentional, planned systems developed in response to customer needs and wants. Things will be the way they are because we intended them to be that way.

We prioritize knowing what our customers want and looking far and wide for proven systems that can deliver on those priorities.

What we are creating is our own customized integration of best ideas and best practices from all over healthcare. We have taken the systems that address our customers needs and wants and modified them to meet our local needs and realities.

All lobbying by departments for more funding must be justified by how it supports the system and furthers the mission and goals of our whole system.

Budgeting, allocation of time and energy, and attention of senior leadership must be driven by intentional, planned priorities and plans.

17. Alignment of Processes

No individual or department can create their own reality

See the list of ways the system aligns priorities for PCP's and rewards them for this alignment.

See list of ways departments are being integrated and creating intentional, written Service Agreements.

18. Improvements in Clinical Quality

Creating an intentional system of care allows the possibility of coordinated approach to many areas. One area of national attention at present is increasing medical quality by simplifying and standardizing processes. Through this effort decreased medical errors should occur and patient safety should increase. At the same time patients will be getting more consistent input and best practices should be spread more quickly.

1 The nursing councils have gone a long ways towards operationalizing this in their areas of influence.

2 SCF has a physician working full time (temporarily) on clinical protocol development in order to disseminate best practices and standardize practice to extent it makes sense to do so.

3 We are putting in place an intentional, planned approach to coordinating improvement activities of all sorts.

19. Facilities

SCF proactively made the ANMC campus work by creating the PCC (Primary Care Center) three years ago.

SCF planned from 4 years ago the expansion of the PCC.

SCF is rapidly designing and building the PCC to handle at least the next 10 years of volume

Considerable work on evaluating and developing off campus capacity for many different programs.

Within the past 12 months and the next 12 months SCF will additionally be providing new or improved facilities for:

Dena-A-Coy (nationally recognized residential treatment program for substance abusing pregnant women)
Early Headstart program
the Pathway Home (a whole system of various levels of care for troubled youth – still in development and recruitment of funding)
Our Mountain View satellite clinic,
Nutaqsiivik (nationally recognized innovative system of intensive case management for socially highest risk families with newborns)
Pacific Home Health - our other home based services including Personal Care
our health promotion and research program,
Quyana Clubhouse (for the chronically mentally ill)and
Our large collection of Behavioral Health programs.

20. Effective Budgeting for the long term

Creating sinking funds for equipment and capital costs should allow the system to remain equipped and housed without crisis intervention long term.

Creating and solidifying components of the system in sustainable ways.

21. Long term thinking and planning

Planning facilities for the long term future

Creating financial tools that allow sustainability

Strong attention to funding sources and sustainable funding

Creation of the Primary Care System was in a forward thinking mode that is creating a system that should be sustainable for the long-term – even if budgets flatten and population increases. Is a much, much more effective and efficient system of care and allows us the possibility of providing care to more individuals over time within available resources. Lots of rework and redundancy are removed.

This new primary care system builds clinically for the long-term as well.

Every primary care visit builds on the previous. Every effort is compounded in positive ways to not just treat acute illness, but to better manage chronic illness, prevent illness, and create the environment for promoting wellness. Actually getting to the underlying root causes of illness (lifestyle decisions, depression, violence, etc) is possible. The rewards of good illness prevention and improved wellness are paid back to the system over decades and lifetimes. In a system such as ours where clients, families and communities use the same system for generations, the system actually gets these paybacks structurally and financially. ***It structurally and financially encourages illness prevention and wellness promotion. All health programs and structures should be like this if illness prevention and health promotion are really to be supported by the healthcare system and healthcare cost are to be controlled..***

22. Creation of a rural ASU system of care

Support of the $5.5m expansion of rural ASU programs
Programmatic and technical support to village systems.
Definition of current system and customer satisfaction with system through the Craciun survey.
Development of an effective, structured method by which SCF and the healthcare system can hear and support the voice of village leadership as the independent voice of the rural Anchorage Service Unit.
Much attention has paid to improving the relationship of SCF to rural ASU groups. Tremendous headway has been made.

23. Continuum of Care

Examples of SCF efforts:
- Purchase of Home Health Agency
- Developed Personal Care Attendant program
- Development underway for Hospice and Respite services.
- Development of Traditional Healing program
- Addition of (limited) Chiropractor services
- (Limited) Acupuncture and Biofeedback services
- Expansion of Community Education efforts
- ***Development of adolescent treatment system – Pathway Home***
- ***Development of adolescent work experiences – summer and winter intern programs (impressive SCF initiative to bridge youth into the work environment and the consideration of choosing work in the healthcare environment – with particular emphasis on at-risk youth).***

24. Development of financial stability, partnerships, and other sources of funding

Continual attention to Federal congressional relationships and continual documentation of needs provided to them to support funding requests.
Astute attention to I.H.S. systems of expanding and solidifying funding.
Attention to competing for all I.H.S. funding sources.
Partnering with city, state, and other partners to extend our funding. Examples:
- Mountain View Clinic partnership with ANHC (community health center)
- Community Mental Health Center grant
- Valley contracts
- Dena-A-Coy partnerships
- Pathway home alliances

Pursuing research and clinical improvement grants:
- CDC Breast and Cervical Cancer Prevention Initiative
- Cardiovascular Risk Reduction research
- Komen Foundation funding
- Run For Women funding
- NIH exploratory grants
- Many, many other corporate based grants.

IV. Remaining needs and SCF plans to meet them

Adolescent programming

Teens are at the top of many disturbing health trends. These include violence of many sorts, substance abuse, suicide, depression, alcohol abuse, inhalant abuse, etc, etc. Alaska Native youth top all lists for many reasons. Some of them have to do with the transitions from village to urban life, from the lack of clear future possibilities, from a loss of identity as a Native youth, and much more.

SCF Plans:

The Pathway Home program – this is a comprehensive system of programs from residential treatment for high risk and medium risk youth and outpatient treatment for lower risk youth. The program will include therapy, job training, completion of high school education, and employment skills.

Intern Trainee program – SCF has already developed this program and has had several hundred youth in it. This program exposes Native youth to the healthcare environment and the world of work in a controlled, intentional way. It helps bridge from school to work and assists youth in completing high school and moving on to further education and training.

Home Health Care

Indian Health Service has not provided home based services. We have quite a number of persons for whom receiving care in their home would be very advantageous. Getting the right care to those confined to their homes provides better outcomes and better patient satisfaction while decreasing hospitalizations and overall cost. The VA did a very large project where they provided intensive home based services and lowered overall health system costs to one-sixth of the cost! The ANMC hospital facility is full most of the time and the system has limited funding. It would appear that our system would benefit greatly from expanded home based care.

SCF Plans:

We have acquired a home health agency. We are seeking funding to expand the system to the point it can be an effective addition to the healthcare system.

Hospice

Helping patients spend their last months with family in the setting and the way they choose is a strong Native cultural priority. I.H.S. provided for no hospice care. It is unforgivable the Native patients and families are not provided this important option. There is also impressive research data to show that effectively run Hospice programs can decrease costs in the last year of life to one fourth of what is the usual amount spent!

SCF Plans:

SCF is exploring what is required to provide certified, capable hospice care. We are actively pursuing all funding sources we can to try to

provide this important service.

Mental Health Services

As our greatly improved primary care services work at getting to the underlying issues of illness and wellness, we uncover a great deal of mental health issues. It is imperative that we be able to provide the extent of mental health support to our primary care system.

SCF Plans:

Expand mental health services as we are able.

5. Health Information Management

Our system is structured around putting health information into the hands of our clients and helping them make decisions about their health issues.

SCF Plans:

Create a Patient Resource Center. We are working with consultants to create systems of health information for clients and staff that put the appropriate information in their hands when and where they need it.

Create a comprehensive system of information management for our clients. We are designing a system where the information desk staff, the receptionist staff, the health information staff, and other support staff are part of an intentionally designed system of information management to help our clients find what they need in services and information.

Integrate health information management, our community education system, our nutritionists, our patient advocates, and our social workers into a coordinated system of support that works efficiently and effectively for our clients.

Head Start Expansion

Getting young children off on the right foot early in life is critical. As Native families move to the urban setting, getting early educational skills is a challenge for many. We run a limited Head Start program that could be expanded to many, many times its current size in order to meet the need.

SCF Plans:

Open Early Head Start program – just opened by SCF, but limited in size.

Expand Head Start – a high priority.

Complimentary and Alternative Health Services

Just as in the rest of the country, our clients have considerable interest in health services that aren't usually part of the allopathic medical system.

SCF Plans:

We are stepping into this carefully and cautiously. We are providing very limited acupuncture and chiropractor services. We would like to expand both of these services and add massage therapy. We have no plans to expand beyond that at present.

V. Role of Indian Healthcare Improvement Act

We at SCF took an active role in the rewriting of the Reauthorization Act. We worked with other Native leadership from Alaska and across the nation to assure that this document accurately reflects the priorities and needs of our health systems. We believe that the result is a much-improved document that sets the stage for a much better, comprehensive, and well thought our system of care for Alaska Natives and American Indians.

The unfortunate issue is that, while the Act lays out a tremendous vision of what is possible, funding for pursuing this vision remains far, far under what is needed to even begin to meet the goals of the system. It is only right and fair that the first peoples of this proud country get the services they are entitled to as a result of many, many government to government agreements over the years.

We at SCF and ANMC, and many other locations across Indian Country, have demonstrated that we have the expertise and the motivation to provide outstanding services with inadequate funding. We ask that the Improvement Act be passed as we have presented it and that adequate funding be provided to implement it and give us a reasonable chance of bringing the health indicators in Indian Country to at least the level of the rest of the country. It is only right and only fair. We are capable of great things. We have proven it.

Southcentral Foundation

Further Testimony on the reauthorization of the Indian Healthcare Improvement Act

Answers to further questions from Senator Ben Nighthorse Campell sent to me on May 24, 2000 in response to testimony delivered by me on May 10, 2000

Douglas Eby MD MPH FAAFP
Southcentral Foundation
Anchorage, Alaska
June 14, 2000

Introduction

Thank you again for the tremendous opportunity to discuss with you what we have done as a tribal health corporation providing health services through funding from I.H.S. and other sources. We strongly believe in the customer-owner model of health care made possible by compacting. We are proud to be able to provide you with an example of why the reauthorization of the Indian Healthcare Improvement Act and further marked expansion of funding for these programs is a good investment in addition to being a right of American Indians and Alaska Natives.

I am responding once again on behalf of the SCF Board of Directors, my CEO – Katherine Gottlieb MBA, and the leadership and staff of Southcentral Foundation. I am responding to the follow-up questions sent me after my May10th testimony. It is an honor to be given the opportunity to provide you with further information. I look forward to your ongoing interest and support of our efforts to work with the Native [illegible] move towards health and wellness.

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1. Why is a community and relationship based system so important to Alaska Natives?

There are many reasons – most are not specific to Alaska Natives and a few are. If you are truly trying to use your healthcare system to move towards health and wellness, not just the treatment of disease, then health education and lifestyle change are critically important. Health education research and publications are full of examples where the education could produce change that was sustained for months, but seldom is there real demonstrable effect long-term. The exceptions are in those settings where the education is based in a long-term provider-patient relationship where the educational messages can be reinforced over time and where trust between provider and patient is high.

Trust is a critical piece of successful healthcare. Often the most trusted health advisors are the patient's non-medical friends. The reason is trust and more openness to share what is 'really' going on. In a healthcare system that is community based and does everything possible to create ongoing relationship between patient and provider, trust builds and builds resulting in the patient being more willing to open up and get to 'deeper' issues that underlie true health and wellness. The patient also trusts the information and recommendations from the provider more since they create a long-term relationship.

One final general fact is that patients get really tired of repeating their health history to every new provider and nurse they see. When you get to the core issues that annoy people about the healthcare system, this is a big one. It also means that when you start at the beginning each time, you only have time to deal with the superficial, immediate issues and the true determinants of health – those underlying issues – never get touched.

Native cultures in Alaska (and elsewhere) have a strong emphasis on family and community. The individual draws identity more from family and community than from self. Native values understand that happiness, success, and wellness are difficult if not pursued in family, community, and long-term relationship.

For any healthcare system to become successful, it must be appropriate for, and sensitive to, the culture(s) within which it functions. A Native healthcare system must be community and family oriented or it will never reach the levels of success that are possible. In Native communities you first build connection and relationship and then you do your business. It is a relationship based way of living. The healthcare system for this community must be built around these same valued to be successful.

In summary, we have patients, families, and whole communities that relate to us for their whole life – for generations! We are customer-owned and managed. We are a healthcare system in a community that values community, family, and relationship highly. We have the opportunity in this type of setting to do what few health systems can. We can build long-term individual, family, and community relationships in a healthcare setting that truly give us the opportunity to get to the core issues that build health and wellness. It is

an opportunity that must be, and is in some locations, recognized in order to be used to the benefit of those who use this healthcare system.

2. Why do you feel it is important to have Alaska Natives involved in every level of operation of your facility/system?

About 7 years ago the US Congress appointed an Alaska Native Task Force. It was composed of primarily Alaska Native leaders and a few non-Native appointees. The task force produced a large, three volume written summary about all issue facing Alaska Natives. It addressed such things as housing, transportation, education, employment, resource development, subsistence lifestyle, and many other issues in addition to health. After all was said and done the executive summary of this major project said one issue rose above all others and was central to the long-term success of Alaska Native peoples. That issue was dependency. Through the military, government programs of many types, education systems, missionaries, and, yes, the healthcare system, it was the opinion of this knowledgeable group that breaking the cycle of dependency was critical.

In the past healthcare systems have created dependency everywhere. Fortunately this has improved a lot over time, but it remains an issue everywhere. I.H.S. systems run from a central office very distant from the service delivery locations, historically led by non-Native individuals, with doctors and nurses who mostly go in Indian Country for short periods of time, are naturally going to further dependency issues. Indian Self-Determination and the recruitment of more and more Indian/Native individuals into healthcare clinical positions and professional management at all levels has gone a long way towards remedying these issues.

A critical way to work at issues of dependency is to provide training and employment. It is also to provide Native role models and every increasing opportunities for advancement and to build confidence and capability. Some of the most critical ways that the system can help build health and wellness in the Native community is through the development of Native staff. They become leaders and role models in their family, their immediate community, and the larger Native community. Their sense of capability and confidence extends to those around them and inspires others to reach higher and move towards less dependent lifestyles.

The other level of Native involvement in healthcare is at the patient and family level. In SCF's mission/vision/key points statements the first key point is 'Shared Responsibility'. SCF believes that we are partners with the individual, family, and community, working with them to help them with issues related to health and wellness. We actively seek doctors and other staff who are a good 'fit' for us – not just those with the most impressive credentials. We are serious about finding professionals and developing all of our staff with an emphasis on helping the patient, family, and community be able to do more and more for themselves and take control of their own health issues. Self care is not a new concept and is more and more prevalent across the country, but we make it a

particularly strong emphasis in our system. It is what our customer-owners want and it is a very strong way to get at issues of dependency, illness, health, and wellness.

There are also some more specific cultural issues. Alaska Native ways tends towards quiet listening, just 'being' with someone, not directly confronting individuals, waiting patiently, and sensing the spirit of others. These are broad generalities with many exceptions, but generally true nonetheless. There is a lot that 'outsiders' can learn, but it is a slow process and one can never completely become 'Native' if not Native.

There is therefore a tremendous advantage to having leadership and staff that are Native. It is more likely that they will just 'know' the right way to be and to relate as they work in a healthcare setting. Trust and relationship are more quickly built. This is critically important to the success of any healthcare system, as addressed in question #1.

In summary, by emphasizing a system that encourages patient self-care, Native hire and development, and continual focus on our patients and our staff, we can help in the struggle against dependency and the movement towards health and wellness. Our structures, our corporate culture, and our service delivery systems must be intentionally planned and built around these priorities. It is the only way that makes sense in our setting.

3. Can you give some examples of how that (integration of Traditional Healing) works?

Traditional healing can be talked about in two pieces for the purposes of discussion (although such a division is somewhat artificial). There are traditional ways that promote health and healing and are widely practiced. There are also specific individuals that others look to as 'Traditional Healers' or 'Tribal Doctors'.

We incorporate Traditional ways into many of our programs in both intentional and unintentional ways. Our residential treatment program for substance abusing pregnant women emphasizes reconnecting with Native ways and uses many Traditional approaches and activities. Our 'Young Warriors' groups for adolescents uses many traditional activities. All of are many mental health programs use many Traditional methods and activities. Even in our research activities we use Traditional ways.

At present we employ one Tribal Doctor or Traditional Healer. She works directly in our medical outpatient facility and works in close conjunction with our medical staff. For the most part they refer patients back and forth, but do jointly consult on some patients. We have had this actively in place for only a year, but consider it very successful and wish to expand it. At present our medical staff have found it a positive experience.

Healthcare systems that exist in the US at present are for the most part focused on physical illness and wellness. These healthcare systems do some work with mental health, but often in a 'separated out' way. These systems do little around spiritual

wellness. Our Traditional Healing part of what we do gives us expertise and tools to use that expands our ability to deal with spiritual, emotional, and mental aspects of health, illness, and wellness. It increases our ability to deal with the whole person as a whole person.

4. Why is an integrated system so important?

Patients are tired of having to go from place to place for artificially divided pieces of who they are. They are tired of telling their story over and over again. They are tired of having multiple providers for one family. They are tired of the left hand not knowing what the right hand is doing in what is supposed to be one system of care.

We have declared that the whole system will work in ways that make sense to the patient. Much further detail of what we have done is available in my written testimony provided on May 10th.

The reason this matters is improved quality of care and extending our dollars as far as we can. The Native health system of this country is woefully underfunded. Critical health needs are going unmet. With such limited funding we must find ways to take the dollars we do have and stretch them as far as possible. We can provide much more service for the same funding if we create an intentional, planned, coordinated system where duplication of effort is minimized, hand-offs are smooth, and the patient gets the right thing at the right time, in a way that they find pleasing.

The other reason is quality and patient safety. There is increasing awareness across this country that quality is uneven and patient safety is compromised in way too many instances. By creating an intentional planned system of care you can markedly improve quality and decrease errors that endanger the patient. This is a very big topic worthy of a very long discussion, but suffice it to say that systems of care with careful attention to quality and safety in a the very complex healthcare arena are far better and safer than systems that leave it to individual capability.

5. How have you funded your Primary Care Center and its expansion?

We have done this facility expansion through a number of creating ways. We have strongly benefited from our connections to our for-profit corporate 'parent' – CIRI (Cook Inlet Region Inc.). They built the initial facility and then later sold it to us. They have provided considerable real estate and building expertise for us on an ongoing basis.

We have use municipal bonds to finance many of the costs. As a not-for-profit corporation we have access to this type of funding source and have used it well.

We have worked closely with the municipality and other community agencies to build alliances across our system of care. This has helped with community grants and planning and zoning issues as they have arisen.

We have also very closely and carefully managed our resources. As a compacted tribe working in a not-for-profit corporate environment we have used our ability to chart our own course to our benefit. We have highly capable finance leadership and staff who have dramatically affected our sophistication in funding our many projects.

6. (Access challenges for same day service at satellite locations)

We provide same day access at all of our locations. We have a satellite clinic in Anchorage that is a partnership with the local non-Native community health center. We contribute to the operation of the clinic in such a way that our patients are guaranteed the same extent of access as in our central location.

The other locations we discussed briefly during the verbal questions on May 10th affected the villages. There are 55 villages in the Anchorage Service Unit, for which we are the physician-based hub. These are remote villages mostly accessible only by small planes. We do provide these persons with exactly the same type of access if they can get to Anchorage. Our system also assists with travel money for most health-related travel from the villages. We also provide continual, all day phone access for the health aides who are based in these villages seeing patients.

So, we do provide immediate access for any and all primary care needs across all locations in our system of care. It just varies in exactly how that is accomplished from location to location.

Final Comments

Thank you once again for the opportunity to share with you what we have been able to accomplish at Southcentral Foundation. We believe in taking the funds we are able to obtain and making an outstanding system of care to the extent that funding allows. We are confident we can provide a quality product with whatever amount of funding we can obtain. The extent of the service is what will be limited by the amount of funding.

We strongly agree with other testimony you have heard that the level of funding provided to Indian Country is woefully inadequate. We strongly support the Indian Healthcare Reauthorization Act and the comprehensive picture of a good healthcare system it paints. We also strongly support funding adequate to fulfill the vision of this document.

We believe we are a strong example of what success can look like in a Self-Determination, customer-owner environment when an unrelenting commitment to quality and to the customer is present and an continual search for better ways of providing healthcare is taken on. We are proud of what we are doing and invite any of you who wish to better understand what we have been able to do to visit us or talk with us further.

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